CATEGORY 1 - APPLICABILITY

Q1. To whom do the OASIS requirements apply?

A1. The comprehensive assessment and OASIS data collection requirements apply to Medicare certified home health agencies (HHAs) and to Medicaid home health providers in States where those agencies are required to meet the Medicare conditions of participation. The comprehensive assessment requirement currently applies to all patients regardless of pay source, including Medicare, Medicaid, Medicare managed care (now known as Medicare Advantage), Medicaid managed care, and private pay/including commercial insurance. The comprehensive assessment must include OASIS items for all skilled Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of 18, patients receiving maternity services, and patients receiving only chore or housekeeping services. Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients. OASIS requirements for patients receiving only personal care (non-skilled) services have been delayed since 1999. The transmission requirement currently applies to Medicare and Medicaid patients receiving skilled care only. **Note**: The Medicare PPS reimbursement system requires a PPS (HHRG/HIPPS) code to be submitted on the claim of any Medicare PPS patient under 18 or receiving maternity services. While the OASIS data set was not designed for these population types, and is not required by regulation to be collected, in these rare instances, HHAs desiring to receive payment under Medicare PPS would need to collect the data necessary to generate a HHRG/ HIPPS code. The HHA is not required to transmit these data to the State. (You can read or download the December 2003 notice from http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage. Search for 04-12)) [Q&A EDITED 08/07]

Q2. Would OASIS be completed on a 22-year old female who is receiving home care because of an infected C-section incision?

A2. A 22-year old female who is a post-partum patient (i.e., treatment is provided for conditions related to pregnancy and/or childbirth) would be excluded from the OASIS collection requirement unless that patient was a Medicare PPS patient, as noted in the response to Q1.

Q3. How do the OASIS regulations apply to Medicaid HHA programs? Do the OASIS regulations apply to HHAs operating under Medicaid waiver programs?

A3. The OASIS regulations apply to HHAs that must meet the home health Medicare conditions of participation (CoP). An agency that currently must meet the Medicare CoP under Federal and/or State law will need to meet the CoP related to OASIS and the comprehensive assessment. If an HHA operates under a Medicaid waiver, and if that State's law requires HHAs to meet the Medicare CoP in order to operate under the Medicaid waiver, then OASIS applies. If an HHA operates under a Medicaid waiver, and if that State's law does not require that the HHA meet the Medicare CoP in order to operate under the Medicaid waiver, then OASIS does not apply. HHAs should be aware of the rules governing HHAs in their State. Currently, OASIS requirements apply to all patients receiving skilled care reimbursed by Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of

18, patients receiving maternity services, patients receiving only chore or housekeeping services. OASIS requirements have been delayed for patients receiving only personal care (non-skilled) services.

Q4. We are an HHA that also provides hospice services. Do the OASIS requirements apply to our hospice patient population? What if they are receiving 'hospice service' under the home care agency (not the Medicare hospice benefit)? Would OASIS apply?

A4. Medicare conditions of participation (CoP) for home health are separate from the rules governing the Medicare hospice program. Care delivered to a patient under the Medicare home health benefit needs to meet the Federal requirements put forth for home health agencies, which include OASIS data collection and reporting for skilled Medicare and Medicaid patients. Care delivered to a patient under the Medicare hospice benefit needs to meet the Federal requirements put forth for hospice care, which do not include OASIS data collection or reporting. However, if a Medicare patient is receiving skilled terminal care services through the home health benefit, OASIS applies. [Q&A EDITED 08/07]

Q5. We have a branch of our agency that serves non-Medicare patients. Can you elaborate on whether we need to do the comprehensive assessment with OASIS for these patients? We do serve Medicaid patients from this branch --does this make a difference?

A5. If an HHA is required to meet the Medicare conditions of participation (CoP), then all of the CoP apply to all branches of that agency including the comprehensive assessment and OASIS data collection. Whether the agency has different branches operating under a single provider agreement/number serving different patient populations does not matter. Some States, as a part of State licensure or certification, allow HHAs to establish completely separate entities for serving other than Medicare/Medicaid patients. If the separate entity does not have to comply with the Medicare CoP for any reason (e.g., they do not have to meet the Medicare CoP to compete for managed care contracts, etc.) and the individual State does not require Medicare compliance, then none of the CoP applies. To be considered a separate entity, several requirements must be met, including separate incorporation for tax and business purposes, separate employer IDs, separate staff, separate billing and cost reporting systems, etc. If this separate entity is not meeting the Medicare CoP, then it cannot be using Medicare certification for any reason, including payment or competing for contracts.

Q6. Does the patient's payer source matter? Should we collect OASIS data on private pay patients who are only paying for aide service? What about a patient receiving therapy services under Medicare Part B?

A6. Effective December 8, 2003, OASIS data collection for non-Medicare/non-Medicaid patients was temporarily suspended under Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Note that the conditions of participation (CoP) at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status

and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use. A Survey and Certification Memo (#04-12) sent to surveyors on 12/11/03, further explains the requirement change. It is accessible at http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage (Search for 04-12)
If the agency provides services to a private pay patient paying for personal care services only, e.g. aide services the agency would be required to conduct a comprehensive assessment, excluding OASIS, of the patient. A comprehensive assessment is not required if only chore or housekeeping services are provided.

The Medicare home health benefit exists under both Medicare Part A and Medicare Part B. Patients receiving skilled therapy services under the Medicare home health benefit that are billed to Medicare Part B would receive the comprehensive assessment (including OASIS items) at the specified time points if care is delivered in the patient's home. If a Medicare patient receives therapy services at a SNF, hospital, or rehab center as part of the home health benefit simply because the required equipment cannot be made available at the patient's home, the Medicare conditions of participation apply, including the comprehensive assessment and collection and reporting of OASIS data. However, if the services are provided to a patient RESIDING in an inpatient facility, then these are not considered home care services, and the comprehensive assessment would not need to be conducted.

If a Medicare beneficiary receives outpatient therapy services from an approved provider of outpatient physical therapy, occupational therapy, or speech-language pathology services under the Medicare outpatient therapy benefit (as opposed to the Medicare home health benefit), then OASIS requirements would not apply. Bear in mind that under PPS, if the patient is under a home health plan of care, the outpatient therapy is bundled into the prospective payment rate and is not a separate billable service. See our February 12, 2001 Survey and Certification memorandum (#3 for 2001) at http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage, "The Application of OASIS Requirements to Medicare Beneficiaries...," for more information on the applicability of OASIS to Medicare beneficiaries. [Q&A EDITED 08/07]

Q7. When a nurse visits a patient's home and determines that the patient does not meet the criteria for home care (e.g., not homebound, refuses services, etc.), is the comprehensive assessment required? What about OASIS data collection?

A7. If the individual was determined to not be eligible for services, the patient would not be admitted for care by the agency, and no comprehensive assessment or OASIS data collection would be required. No data would be transmitted to the State agency.

Q8. A patient turns 18 while in the care of an HHA -when do we do the first OASIS assessment?

A8. If the patient is under age 18 and the home care is covered under Medicare PPS, the HHA must complete the comprehensive assessment, including the OASIS, to obtain a Medicare PPS (HHRG/HIPPS) code. The HHRG/HIPPS code is submitted on the request for advance payment (RAP). The OASIS data would not be submitted to the State OASIS system. For a skilled Medicare/Medicaid patient who turns 18 while under the care of an HHA, the comprehensive assessment with OASIS data collection and submission to the State OASIS system would occur the first time one of the following events takes place: 1-When patient returns home from a qualifying inpatient stay - Resumption of Care, i.e., RFA#3; 2-When patient is transferred to an inpatient facility for 24 hours or longer (for a reason other than diagnostic tests) -Transfer to an Inpatient Facility -RFA#6 if not discharged from the HHA or RFA#7 if discharged from the HHA; 3-When the 60 day recertification is due, i.e., the last five days of the certification period -Follow-up, i.e., RFA#4; 4-When there is a major decline or major improvement in the patient's condition to update the care plan -Other follow-up, i.e., RFA#5; or 5-On death of the patient at home, or when the patient is discharged from the agency i.e., RFA#8 - death or RFA#9 -normal discharge.

If the patient is not a Medicare or Medicaid patient, other regulations apply. Effective December 8, 2003, OASIS data collection for non-Medicare/non-Medicaid patients was temporarily suspended under Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Note that the conditions of participation (CoP) at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use. To access the CoP, go to http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

A memo was sent to surveyors on 12/11/03, "The Collection and Transmission of the Outcome and Assessment Information Set (OASIS) for Private Pay Patients," which you can access by going to the CMS OASIS web site at http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage, scroll down and click on "Survey and Certification Policy Memoranda," it is memo 04-12 on the list for 2003. [Q&A EDITED 08/07]

Q9. Can you explain the term 'skilled service?'

A9. Skilled services covered by the Medicare home health benefit are discussed in the Medicare Benefit Policy Manual. This publication can be found on our website at: http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf. [Q&A EDITED 08/07]

Q10. What is the current status of OASIS applicability to patients receiving only personal care services?

A10. The applicability of OASIS to patients receiving only personal care services is delayed and will remain so until a new Federal Register notice is published that announces otherwise.

Q11. Do we need to collect OASIS on a patient admitted to home health with post-partum complications? If we open a patient 2-3 months after a C-section for infection of the wound, do we collect OASIS, or do we consider this "maternity"? What is the definition of "maternity" and when do we collect OASIS on these patients?

A11: In the OASIS User's manual, Chapter 4, Section C, it clarifies that the Conditions of Participation do not require OASIS data collection for patients receiving only maternity-related services.

Post-partum complications and a wound infection in the C-section incision are only possible in maternity patients. You are not required to collect OASIS on maternity patients unless the payer requires the data collection for payment. Maternity patients are patients who are currently or were recently pregnant and are receiving treatment as a direct result of the pregnancy.
[Q&A ADDED 08/07; Previously CMS OCCB Q&A 05/07 #1]

CATEGORY 2 - COMPREHENSIVE ASSESSMENT

Q1. Are OASIS data collected on patients that are recertified or only on patients that are transferred or discharged?

A1. The condition of participation (CoP) published in January 1999 requires a comprehensive patient assessment (with OASIS data collection) be conducted for all adult, nonmaternity patients receiving skilled care at start of care, at resumption of care following an inpatient facility stay of 24 hours or longer, every 60 days or when there is a major decline or improvement in patient's health status, and at discharge or transfer to an inpatient facility.
OASIS data collection, effective December 8, 2003, is required for skilled Medicare and skilled Medicaid patients only. Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (http://www.treas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf) temporarily suspends the requirement that Medicare-certified home health agencies collect OASIS data on non-Medicare/non-Medicaid patients. Note that the CoP at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use.
A Survey and Certification Memo (#04-12) sent to surveyors on 12/11/03, further explains the requirement change. It is accessible at http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage (Search for 04-12)
Note that a private pay patient is defined as any patient for whom M0150 Current Payment Source for Home Care does **NOT** include responses 1, 2, 3, or 4. If a patient has private pay insurance in conjunction with M0150 response 1, 2, 3, or 4 covering the care the agency is providing, then OASIS data must be collected (this includes patients for whom Medicare may be a secondary payer). [Q&A EDITED 08/07]

Q2. In my agency, we have 'maintenance' type patients. For example, in one case a monthly visit was made on March 20, 2000, and we found that a patient had been hospitalized March 2, 2000. We were not notified of that hospitalization. The patient had returned home, and no problems were noted. What would I need to do to comply with the OASIS collection requirements?

A2. In most cases, a hospitalization of 24 hours or more, which occurs for reasons other than diagnostic testing, is a significant event that can trigger changes in the patient and may alter the plan of care. When you learn of a hospitalization, you need to determine if the hospital stay was 24 hours or longer and occurred for reasons other than diagnostic testing. If the hospitalization was for less than 24 hours (or was more than 24 hours but for diagnostic purposes only), no special action is required. If the hospitalization did meet the criteria for an assessment update, complete an assessment that includes the Transfer to Inpatient Facility OASIS data items using response 6 in M0100 - Reason Assessment is Being Completed. Enter March 20, 2000, as the response to M0090 (the date you learned of the hospitalization) and March 2, 2000, in M0906 (the actual date of

the transfer). You have 2 days from the point you have knowledge of a patient's return home from an inpatient stay to complete the Resumption of Care assessment, selecting response 3 for M0100. M0090 will be the date the assessment is actually completed. The Resumption of Care Date (M0032) would be the first visit after return from the hospital, i.e., March 20, 2000 in this example. When completing the Resumption of Care (ROC) assessment, follow all instructions for specific OASIS items. For example, in responding to M0175, when the inpatient facility discharge date was more than 14 days prior to the ROC date, NA is the appropriate response. M0180 and M0190 thus will not be answered. [Q&A EDITED 08/07]

Q3. Do we have to complete an OASIS discharge on a patient who has been hospitalized over a specific time period?

A3. The agency will choose one of two responses to OASIS item M0100 when a patient is transferred to an inpatient facility for a 24-hour (or longer) stay for any reason other than for diagnostic testing:

M0100=6 - Transfer to an Inpatient Facility--patient not discharged from agency; or
M0100=7 - Transfer to an Inpatient Facility--patient discharged from agency.

The agency's internal policies should guide the decision whether or not to discharge a patient. For additional guidance on transferring Medicare PPS patients with or without discharge, see the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website
https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf
[Q&A EDITED 08/07]

Q4. May an LPN, OTA, or PTA perform the comprehensive assessment?

A4. No. An LPN, OTA, and PTA are clinicians that are not qualified to establish the Medicare home health benefit for Medicare beneficiaries or perform comprehensive assessments.

Q5. What Comprehensive assessments do I need to complete on my Medicare PPS patients?

A5. You must conduct a comprehensive assessment including OASIS data items at start of care, at resumption of care following an inpatient facility stay of 24 hours or longer, every 60 days, and at discharge. When a patient is transferred to an inpatient facility or dies at home, a brief number of OASIS data items must be collected, but no Discharge comprehensive assessment is required. [EDITED 08/07]

Q6. Does information documented in OASIS have to be backed up with documentation elsewhere in the patient's records?

A6. There is no regulatory requirement that OASIS assessment data be duplicated elsewhere in the patient record. However, we expect patient needs that have been assessed in the agency comprehensive assessment would be reflected in the patient's medical record or plan of care. This is in accordance with Condition of Participation (CoP) 42 CFR 484.48, Clinical Records, requiring a clinical record containing pertinent past and current findings in accordance with accepted professional standards be maintained for every patient receiving home health services. (The CoPs can be read or

downloaded from http://www.cms.hhs.gov/providers/hha/#oasis, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.)
For example, if the response for OASIS item M0250 - Therapies the patient receives at home, were 1, 2, or 3, then the medical record should reflect appropriate interventions and physician orders to provide the required intravenous or infusion therapy, parenteral, or enteral nutrition. The clinical record would also have appropriate documentation of the implementation and evaluation of the interventions. The medical record and the plan of care should reflect the aspects of care for which the HHA has responsibility, including the therapy(ies) provided at home. Documentation in the clinical record, for example, may indicate that the patient and caregiver are learning all aspects of administering the therapy, with an outline of the focus of education and assessment provided by the agency. Another patient/caregiver may be independent with providing the therapy, but the HHA is periodically re-evaluating the patient's nutritional and fluid status during this episode.
Another example would be OASIS item M0390, Vision, with a response of 1 or 2. This would mean that for response 1, the patient has partially impaired vision, i.e., the patient cannot see medication labels. Therefore, the plan of care would need to document the plan for ensuring that the patient receives the correct medications at the correct times, and the clinical record would contain documentation of the education provided and evaluation of the interventions implemented.

Q7. At Recertification, our agency collects only the Reduced Burden OASIS items. Is this sufficient to meet the CoP for the follow-up assessment?

A7. The OASIS items alone are not a complete comprehensive assessment and must also have the agency-determined components of the Follow-Up comprehensive assessment. Please refer to Appendix C of the *OASIS User's Manual* (available at http://www.cms.hhs.gov/oasis/usermanu.asp) for sample clinical forms demonstrating the integration of OASIS items into comprehensive assessments, one for each time point. [Q&A EDITED 08/07]

Q8 [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat 4b, Q15]

Q9. Who can perform the comprehensive assessment when RN and PT are both ordered at SOC?

A9. According to the comprehensive assessment regulation, when both disciplines are ordered at SOC, the RN would perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

Q10. Who can perform the comprehensive assessment when PT is ordered at SOC and the RN will enter 7-10 days after SOC?

A10. If the RN's entry into the case is known at SOC (i.e., nursing is scheduled, even if only for one visit), then the case is NOT therapy-only, and the RN should conduct the SOC comprehensive assessment. If the order for the RN is not known at SOC and originates from a verbal order after SOC, then the case is therapy-only at SOC, and the therapist can perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

Q11. Who can perform the comprehensive assessment for a Medicare PPS patient when PT (or ST) is ordered along with an aide?

A11. Because no nursing orders exist, the PT (or ST) could perform the comprehensive assessment at the SOC and all subsequent assessments. [Q&A EDITED 08/07]

Q12. Who can perform the comprehensive assessment for a therapy-only case when agency policy is for the RN to perform an assessment before the therapist's SOC visit?

A12. A comprehensive assessment performed on a date BEFORE the SOC date cannot be entered into HAVEN (or HAVEN-like software). Since the regulations allow for the comprehensive assessment to be conducted by the therapist in a therapy-only case, the agency may consider changing its policies so that the therapist could perform the SOC comprehensive assessment. If the agency chooses to have an RN conduct the comprehensive assessment, the RN should perform an assessment on or after the therapist's SOC date (within 5 days to be compliant with the regulation). [Q&A EDITED 08/07]

Q13. Who can perform the comprehensive assessment when OT services are the only ones ordered for a non-Medicare patient?

A13. The Occupational Therapist (OT) can perform the assessment if OT services establish program eligibility for the non-Medicare payer. While OT cannot establish program eligibility for Medicare patients, that may not be applicable to other payers. The OT may conduct subsequent assessments of Medicare patients. [Q&A EDITED 08/07]

Q14. Who can perform the comprehensive assessment when both RN and PT will conduct discharge visits on the same day?

A14. When both the RN and Physical Therapist (PT) are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

Q15. Can the MSW or an LPN ever perform a comprehensive assessment? What about therapy assistants?

A15. According to the comprehensive assessment regulation, a MSW or LPN is not able to perform the comprehensive assessment. Only RN, PT, SLP (ST), or OT is able to perform the assessment. Therapy assistants are also not able to perform the comprehensive assessment. This is no different from the previously existing Medicare conditions of participation (CoP) that set forth the qualification standards for those conducting patient assessments. The CoP can be read or downloaded from http://www.cms.hhs.gov/providers/hha/#oasis, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

Q16. How does the agency develop a SOC comprehensive assessment that is appropriate for therapy-only cases?

A16. Discipline-specific comprehensive assessments are expected to include: the OASIS items appropriate for the specific assessment (i.e., SOC, follow-up, etc.); agency-

determined 'core' assessment items (appropriate for use by any discipline performing a comprehensive assessment); and discipline-specific assessment items. The combination of these components in an integrated form would constitute a discipline-specific comprehensive assessment for the appropriate time point. Discipline-specific assessment forms are available from commercial vendors and may be available through some professional associations. This subject is discussed more fully in Chapters 4 and 7 of the *OASIS User's Manual*, available at http://www.cms.hhs.gov/oasis/usermanu.asp. Please refer to Appendix C of the OASIS User's Manual (available at http://www.cms.hhs.gov/oasis/usermanu.asp) for sample clinical forms demonstrating the integration of OASIS items into nursing comprehensive assessments, one for each time point. [Q&A EDITED 08/07]

Q17. Are we required to discharge patients from the agency when they are admitted to an inpatient facility?

A17. The agency may develop its own policies and procedures regarding discharging patients at the time of admission to inpatient facilities, but must be cognizant of the billing implications for Medicare PPS patients. Questions about billing must be directed to the agency's Regional Home Health Intermediary (RHHI).
For guidance on transferring patients with or without discharge, refer to the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf.

Q18. I understand that the initial assessment visit (or Resumption of Care assessment) is to be done within 48 hours of the referral (or hospital discharge). What do we do if the patient puts us off longer than that? For example, the patient says, "I have an appointment today (Friday); please come Monday."

A18. The initial assessment visit is to be done within 48 hours of the referral OR on the physician-ordered date. In the absence of a physician-ordered SOC date, if the patient refuses a visit within this 48-hour period, the agency should contact the physician to determine whether a delay in visiting would be detrimental to the plan of care. The call should be documented in the patient's chart for future reference. The ROC visit is to be done within 48 hours of the patient's hospital discharge. The agency should contact the physician to determine whether a delay in visiting will be detrimental. At the ROC, there is no regulatory language allowing the ROC to be delayed by physician order, greater than 48 hours from the inpatient facility discharge. The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record. [Q&A EDITED 08/07]

Q19. An RN visited a patient for Resumption of Care following discharge from a hospital. The nurse found the patient in respiratory distress and called 911. There was no opportunity to complete the Resumption of Care assessment in the midst of this situation. What should be done in this situation?

A19. Any partial assessment that was completed can be filed in the patient record, but HAVEN (or HAVEN-like software) will not allow a partial assessment to be exported for submission to the State agency. In situations like this, a note explaining the circumstances for not completing the assessment should be documented in the chart. If,

after the 911 call, the patient is admitted to an inpatient facility and then later returns home again, a Resumption of Care assessment would be indicated at that point. When the 911 call results in the ER treating the patient and sending the patient back home, the Resumption of Care assessment would be completed at the next agency visit.

Q20. Can you clarify the difference between the 'initial assessment' and the 'comprehensive assessment?'

A20. The initial assessment visit is conducted to determine the immediate care and support needs of the patient and, in the case of Medicare patients, to determine eligibility for the home health benefit including homebound status. If no reimbursable service is delivered, this visit is not considered the SOC and does not establish the SOC date. The SOC comprehensive assessment must be completed on or within 5 calendar days after the SOC date and in compliance with agency policies. In the interest of cost-effectiveness, many agencies have combined the initial assessment with the delivery of skilled service(s), assuming the patient is eligible for home care. This would make the initial assessment and the SOC the same date. Also in the interest of efficiency, many agencies also encourage the admitting clinician to complete the SOC comprehensive assessment on this initial visit as well. In this case the SOC date (M0030) is the same as the date the assessment is completed (M0090). These protocols and procedures are a matter of agency choice and agency policy, as long as the regulatory time requirements are met. [Q&A EDITED 08/07]

Q21. For a discharge assessment, does the clinical documentation need to include anything other than the OASIS discharge items?

A21. The exact content of the discharge comprehensive assessment documentation (other than the required OASIS items) is left to each agency's discretion. To fulfill the comprehensive assessment requirement, agencies should remember that the OASIS data set does not, by itself, constitute a comprehensive assessment. HHAs should determine any other assessment items needed for a discharge assessment and include these in their comprehensive discharge assessment.

Q22. If a patient died before being formally admitted to an inpatient facility, do I collect OASIS for Death at Home?

A22. The OASIS discharge due to death is used when the patient dies while still under the care of the agency (i.e., before being treated in an emergency department or admitted to an inpatient facility). A patient who dies en route to the hospital is still considered to be under the care of the agency and the death would be considered a death at home. A patient, who is admitted to an inpatient facility or the hospital's emergent care center, regardless of how long he/she has been in the facility, is considered to have died while under the care of the facility. In this situation, the agency would need to complete any agency-required discharge documents (e.g., a discharge summary) and a transfer assessment (RFA 7, Transfer to Inpatient Facility, Patient Discharged) to close out the OASIS episode. [Q&A EDITED 08/07]

Q23. A patient recently returned home from an inpatient facility stay. The Transfer comprehensive assessment (RFA 6) was completed. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. She performed CPR and transferred the patient back to the ER where,

he passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required?

A23. The Transfer assessment completed the requirements for the comprehensive assessment. The patient did not resume care with the HHA. The agency's discharge summary should be completed to close out the clinical record.

Q24. Is it ever acceptable for an LPN to complete the OASIS? For example, could an LPN complete the OASIS if she/he were the last to see a patient prior to an unexpected re-hospitalization?

A24. The comprehensive assessment and OASIS data collection must be conducted by an RN, PT, OT or SLP as described in the regulations. This is no different from the previously existing Medicare conditions of participation (CoP) that set forth the qualification standards of those conducting patient assessments. Patient assessment is not included in the duties of an LPN. The CoP can be read or downloaded from http://www.cms.hhs.gov/providers/hha/#oasis, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q25. Do you have any information on what agencies are to do if the beneficiary refuses to answer OASIS questions? For example, some patients felt it was an invasion of their privacy to address question M0300 (about current residence). Are agencies not to admit, based on the refusal?

A25. The OASIS items should be answered as a result of the clinician's total assessment process, not administered as an interview. Conducting a patient assessment involves both interaction (interview) and observation. Many times the two processes complement each other. Interaction and interview (i.e., report) data can be verified through observation - observation data adds to the information requested through additional interview questions. Many clinicians begin the assessment process with an interview, sequencing the questions to build rapport and gain trust. Others choose to start the assessment process with a familiar procedure such as taking vital signs to demonstrate clinical competence to the patient before proceeding to the interview. We suggest that agencies that seem to report a high degree of difficulty with specific OASIS items might be well advised to review with their staff the processes of performing a comprehensive assessment, because all OASIS items are required to be completed. Sometimes such difficulties indicate that clinical staff might benefit from additional training or retraining in assessment skills. The OASIS Web-Based Training (WBT) includes considerable information to help clinicians with assessment processes and can be accessed online at http://www.oasistraining.org/. Remtech Services, Inc. (RSI), the contractor that developed the WBT, has mailed a CD-ROM to all Medicare certified agencies. If your agency cannot locate its copy, and would like to order one, go to http://www.oasistraining.org/ and click on 'Reference', then on 'Contacts'. In addition, a list of supplemental references regarding patient assessment is included in Chapter 4 of the *OASIS User's Manual,* available at http://www.cms.hhs.gov/oasis/usermanu.asp. The Privacy Act Notices are available at: http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage.

Q26. What Privacy Act statements are required since MMA 2003 temporarily suspended OASIS data collection for non-Medicare/non-Medicaid patients?

A26. For non-Medicare/non-Medicaid patients in agencies that temporarily suspended OASIS items in their comprehensive assessment, the Notice about Privacy for Patients Who Do Not Have Medicare or Medicaid Coverage (Attachment C) is not currently required.

For non-Medicare/non-Medicaid patients in agencies that continue to include OASIS items in their comprehensive assessment, the Notice about Privacy for Patients Who Do Not Have Medicare or Medicaid Coverage (Attachment C) is required.

For all Medicare and Medicaid patients receiving skilled services, the Statement of Patient Privacy Rights for Medicare and Medicaid patients (Attachment A) and the Privacy Act Statement (Attachment B) are required.

The Privacy Act Notices are available at
http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage

Q27. What should we do about OASIS when a patient refuses?

A27. Remember that the regulations require that a comprehensive patient assessment be conducted at specified time points, which for some patients includes the use of standardized data items as part of the assessment. These items, of course, are the OASIS data set. To discuss patient refusal, we must first address the components of a patient consent process. Typically, patient consent forms (which must be signed by the patient or their designated representative) include 4 components: a consent to be treated by the HHA; a consent for the HHA to bill the pay source on behalf of the patient; a consent to release patient-specific information to the physician, the patient's insurance carrier or other payer, etc.; and acknowledgement that the patient has been informed of his or her rights and has received written information about these rights. Consenting to treatment (#1) would include the performance of a comprehensive assessment that is necessary to develop a plan of care/treatment; releasing information to the payer source (#3) would include transmitting data to the State agency as a representative of Medicare/Medicaid; and acknowledgement of patient rights (#4) would include the receipt of the Privacy Act statements regarding patient rights. What then is the patient 'refusing,' and what is the HHA's response? Does the patient refuse to be assessed (i.e., refuse to be treated)? Most agencies have written policies (based on input from legal counsel) about how to handle such situations, and whether or not to provide care to a patient who refuses to agree to be treated. Does the patient refuse to have his/her information released (to the physician, to the payer, etc.)? How does the HHA obtain physician orders if no patient-specific information can be released? What information can be provided to the fiscal intermediary (or other pay source) requesting patient records to verify the provision of services, patient eligibility for services, etc.? Again, most HHAs will have obtained a legal opinion and promulgated written policies about providing services to a patient who refuses to consent to release of information.

During the comprehensive assessment, does the patient refuse to answer a specific interview question -- for example, "What is your birth date?" In this case, please recall that the OASIS items are not an interview, but rather request standardized information on each HHA patient. Nearly all OASIS items can be obtained through observation of the patient in the normal assessment process, or through review of discharging facility paperwork or caregiver interview. Many items that can ONLY be obtained by interview have a response option of 'unknown' at SOC. Two exceptions to this include the

patient's Medicare number (M0063), and the patient's birth date (M0066). These data typically are obtained for billing purposes, so we feel confident that HHAs can find other ways to obtain the information. If a patient refuses to answer an interview question, the clinician must assess the patient and record the appropriate response to the OASIS item. Note that all (appropriate) OASIS items must be answered for a specific assessment, or the assessment cannot be transmitted. In the experience of HHAs that used the OASIS data items as part of a comprehensive assessment for well over 3 years during the national demonstration, the items were already part of their clinical documentation -- which means that the clinicians were already assessing patients for these very factors. [Q&A EDITED 08/07]

Note that the Privacy Act statements (to be provided to the patient) are informational in nature. It is expected that they will be presented to (and discussed with) the patient in a way similar to the other patient rights information currently required by the Medicare conditions of participation.

Q28. How are we to handle physical, speech or occupational therapy-only patients when these disciplines do not assess for the same elements as skilled nursing? The data set seems skewed toward nursing issues.

A28. OASIS data items are not meant to be the only items included in an agency's comprehensive assessment. They are standardized health assessment items that must be incorporated/integrated into an agency's own existing assessment processes. For a therapy-only case, the primary therapist may conduct the comprehensive assessment using the comprehensive assessment data items incorporated into their form that includes whatever other inquiries the agency currently makes for therapy-only cases. Refer to Chapters 4 and 7 in the *OASIS User's Manual* for additional discussion of this issue. The manual is available at http://www.cms.hhs.gov/oasis/usermanu.asp.

Q29. We have integrated OASIS data items into our current assessment questions. Staff feels strongly that they need the admission OASIS information as a reference point. My understanding was that staff was NOT to have the original set of OASIS items as a reference.

A29. Your understanding is correct. The instructions about not using previous OASIS data as reference for a later assessment are to decrease the likelihood of clinicians becoming biased in their item response selection or simply 'carrying data forward' rather than actually performing a new assessment. Careful training of your clinical staff, emphasizing the importance of actually conducting a new assessment (rather than recording the same response as before without performing an assessment), is important. Clearly the admission assessment data are useful in reviewing patient progress throughout the care episode. After the follow-up (or discharge) assessment has been performed and the findings documented, reviewing the admission assessment assists the clinician to see exactly what progress has occurred. You might request clarification from your staff as to how they are using the admission data -- and then reinforce the importance of a completely new assessment at the follow-up time point, if necessary. It is important for agencies to keep the big picture in mind, i.e., OASIS is but the first step toward an outcome management paradigm. As such, it is imperative that the clinician collects OASIS data at the required time points with no preconceptions. In this way, she/he is able to accurately document her/his observations of the patient's status at the

time of assessment. It is critical for staff to understand how inaccurate data will affect the agency's outcome reports, as well as the legal clinical record. [Q&A EDITED 08/07]

Q30. For how long a period may agencies place a patient on 'hold' status when the patient has been hospitalized?

A30. At this time, CMS is not defining policy relating to an agency's hospitalization of patients. The agency should carefully consider the requirements for collecting assessment information on patients who are transferred to an inpatient facility for 24 hours or longer (and occurs for reasons other than diagnostic testing). The agency should review their current transfer and discharge policies to determine how the data collection requirements can best be met for transfer to an inpatient facility, resumption of care, and discharge assessments. Bear in mind that certain considerations should be made for your Medicare PPS patients. Refer to the information on the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf for suggestions in keeping your assessments in sync with Medicare billing. [Q&A EDITED 08/07]

Q31. Does OASIS data collection have to be initiated on the very first contact in the home (the initial assessment visit), or is it OK to begin OASIS data collection on the start of care visit, if these two visits are at different times?

A31. The Start of Care OASIS items, which must be integrated into your agency's own comprehensive assessment, must be completed in a timely manner, but no later than five calendar days after the start of care date. The comprehensive assessment is not required to be completed on the initial visit; however, agencies may do so if they choose. [Q&A EDITED 08/07]

Q32. Does the medication list need to be reviewed by an RN if the patient is only receiving therapy services?

A32. The standard for the drug regimen review is not new; it was included in the previous conditions of participation (CoP) under the plan of care requirements. The comprehensive assessment must include a review of all medications the patient is using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The scope of the drug regimen review has thus been narrowed from the previous CoP. Each agency must determine the capabilities of current staff members to perform comprehensive assessments, taking into account professional standards or practice acts specific to your State. No specific discipline is identified as exclusively able to perform this assessment.

Q33. For patients who are discharged after a hospital stay or a visit to the doctor, is it necessary to complete the discharge assessment? We will not be able to make a home visit after the discharge order is obtained.

A33. The patient who is discharged after a hospital stay will have had OASIS data reported at the point of transfer to the inpatient facility. No additional assessments or OASIS data collection are expected in this situation unless a resumption of care occurs. Therefore, the agency will complete any agency-required discharge documents (e.g., a

discharge summary), but no further OASIS data are collected or reported. If the physician determines at an office visit that the patient does not need additional visits and requests discharge, the agency must report the patient status at the last qualifying visit prior to this date (e.g., the last visit performed by a clinician qualified to conduct a comprehensive assessment). When agency staff are aware that the patient's needs for home care are decreasing and that a physician visit is imminent, the possibility of such discharge must be considered. It would be appropriate to update the physician on the progress seen in the home and suggest that it may be time to discharge the patient. Close attention to the details of the comprehensive assessment thus can be incorporated into the home visit scheduled prior to the physician visit. [Q&A EDITED 08/07]

Q34. Is it possible to have two home health agencies independently provide services to a patient, and if so, does each agency complete a comprehensive assessment, including the OASIS data items?

A34. Two participating agencies providing home health services under a Medicare home health plan of care is not allowed under PPS. One agency is the primary provider, whereby the primary provider reimburses the secondary agency under mutually agreed-upon arrangements. In this case, the primary agency is responsible for making sure that comprehensive assessments (including OASIS items) are conducted when due and submitted under the primary agency's name.

Q35. The patient's payer source changes from Medicare to Medicaid or private pay (or vice versa). The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source?

A35. There is a discussion of payer source change in Chapter 8 of the *OASIS User's Manual.* Different States, different payers, and different agencies have had varying responses to payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer this question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source until the patient was discharged. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual.* Go to http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf; scroll to page 94 of the document to read "Section 80 - Special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI. [Q&A EDITED 08/07]

Q36. Could you explain what the term 'start of care' actually means? Is it related to payment?

A36. One of the interesting things about home care is the definition of when the patient is admitted and when the patient is discharged. In contrast to an inpatient setting, where the 'exterior walls' dictate admission and discharge, home care has many variations. Therefore, defining SOC is not as easy as it appears. Start of care currently relates to the 'first billable visit.' The 'first billable visit' approach was selected largely because of the Medicare payment requirements and the fact that the first billable visit defines SOC and the start of the episode for Medicare purposes. A strong case can be made to maintain congruence of the episode dates with the comprehensive assessment requirements. All payers clearly define what is considered a billable visit. However, not all payers require that a skilled provider conduct the first billable visit. For example, an aide might make the first visit (SOC), followed by the RN within the 5-day SOC window, and be perfectly acceptable for that payer. In this example, the episode of care would begin with the aide's billable visit. It has been suggested that we use the agency's initial patient contact as the date of the first assessment, however, it must be noted that the first entry of any care provider into the patient's home may not always occur in close proximity to the episode beginning. For now, SOC will remain linked to the first billable visit.

Q37. Please discuss dealing with 'unplanned or unexpected' discharges.

A37. In providing patient care that focuses on achievement of outcomes, the HHA assumes responsibility for monitoring patient progress and for coordinating care among all participating providers. The agency thus is responsible for planning, coordinating, and communicating about improvement in patient status that can indicate the need for less frequent visits or even discharge. Agencies that do this well will have relatively few 'unexpected' discharges, though such events can occur (for example, when a patient unexpectedly moves out of the service area). To meet the various requirements for the comprehensive assessment, as well as collection and use of OASIS data, the following requirements must be met:

1. the discharge assessment must report patient status at an actual visit (i.e., the clinician must be able to assess the patient, not merely report on patient status from a telephone call);
2. the comprehensive assessment must be conducted by a qualified clinician (RN, PT, SLP, OT);
3. the encoded OASIS data must accurately reflect the patient's status at the time of the assessment; and
4. the HHA's clinical record must contain documentation matching the encoded data sent to the State.

Situation: The nurse conducts a routine visit (not SOC) for Mr. N on August 4. An aide visits August 5 and August 7. On August 8, the physician calls the agency and unexpectedly discontinues home care. What OASIS data are reported? What dates are used for M0090, M0903, and M0906? How does the agency note the patient's status at discharge?

The general principle to follow in these cases is to report the patient's status on the last visit by the clinician qualified to complete the comprehensive assessment with OASIS. We suggest the following approach:

1. All OASIS data required for discharge must be reported. Response 9 for M0100--Reason Assessment is Being Completed will indicate that the patient is being discharged from the agency, but NOT to an inpatient facility.

2. M0090 would be noted as August 8, the date the agency completes the assessment after learning of the need to discharge. (This is the date to be used for compliance with the completion of the discharge assessment and data transmission requirements. Note: Regulation allows up to two calendar days after identification of need to discharge for completion of the discharge assessment.) M0903 - Date of Last (Most Recent) Home Visit would be noted as August 7. M0906 - Discharge/Transfer/Death Date would be reported as August 8 (if your agency defines discharge date as the date the agency is notified of the need to discharge.)

3. To be compliant with the discharge comprehensive assessment requirement, the qualified clinician that last saw the patient should complete the agency's discharge documentation as completely as possible, based on the patient status at that provider's last visit -- in this example, August 4. The clinician should note on this documentation that this is a situation of an unexpected discharge and the discharge assessment is 'based on the visit of mm/dd/yyyy.' The OASIS data from this assessment will be encoded and transmitted. The agency will thus have a discharge assessment recorded and a clinical record document that matches the OASIS data transmitted to the State.

Variation 1: What if the same dates apply to the nurse's visit (August 4) and the date the physician calls the agency to discontinue services (August 8), but there have been no aide visits? What, if anything, is different from the situation described above?

Only one difference exists between this situation and the one described above. That is the date recorded in M0903 - Date of Last (Most Recent) Home Visit. In this variation, the date would be August 4, the date of the nurse's visit.

Variation 2: The situation is the same as Variation 1, but agency policy requires the discharge date to be the date of the last visit. What, if anything, is different from the situation in Variation 1?

The date recorded in M0090 - Date Assessment Completed would be August 8, the date that the agency completed the assessment after learning of the need to discharge. M0903 - Date of Last (Most Recent Home Visit again would be August 4. Agency policy would dictate the date to be recorded in M0906 - Discharge/Transfer/Death Date, which would be recorded as August 4 (the last actual visit). This will produce a warning message in HAVEN or other data entry software, because the assessment was completed more than two days after the discharge. The warning will not hinder locking and transmission of data.

Variation 3: What if the visits on August 5 and August 7 were made by an LPN (or therapy assistant)? What, if anything, is different from the situation described above?

There is no difference from the initial situation described earlier. The LPN (or therapy assistant) is not qualified to perform the comprehensive assessment, therefore the recorded assessment must describe the patient's status at the nurse's (or qualified therapist's) visit. If the LPN/therapy assistant made the last visit before the MD

discontinued services, the LPN/therapy assistant's last visit date would be recorded for M0903. In this case, that date would be August 7.

Variation 4: What if the nurse's August 4th visit was the SOC assessment, followed by the aide visits on August 5 and August 7? What, if anything, is different from the initial situation?

There is no difference from this situation and the initial one described. The HHA must report the patient's status from an actual visit -- in this case, the only possible visit would be the SOC assessment. The qualified clinician must complete the agency's discharge documentation as noted above, with the note that the assessment is 'based on the visit of mm/dd/yyyy.'

Variation 5: What if the nurse makes a visit on August 4, expecting this to be the discharge visit pending a final check with the patient a few days later? A telephone call to the patient on August 8 confirms that the patient is doing well, and the agency discharges the patient. What, if anything, is different from the situations described above?

There are some subtle differences from the situations described above. Because the nurse is expecting the discharge to occur, it is recommended that a complete assessment be recorded on August 4. However, the regulations will require an assessment congruent with the discharge date of August 8. The agency must assure the presence in the clinical record of a discharge assessment completed on (or within 48 hours of) the date recorded in M0090 (August 8 in this example). The HHA has two options for this precise situation: (1) To conduct a (most likely nonreimbursed) visit on or after August 8 to complete another discharge assessment, or (2) To follow the procedures for recording a discharge assessment dated August 8, based on the patient status of August 4 (and so noted in the clinical documentation). Possibly a better option would be to place the telephone call to the patient within 48 hours of the August 4 visit, thus placing the discharge assessment and the discharge date within 48 hours of each other.

Variation 6: The RN's last visit to the patient was July 3, the SOC date. Since then the LPN has been following the patient and her last visit was August 4, with aide visits on August 5 and 7, before the physician called to order the discharge on August 8 because the patient no longer wanted care. Would the RN be allowed to complete the discharge assessment based on the LPN's last visit?

The conditions of participation (CoP) require that a comprehensive assessment (including OASIS items) be conducted at the time of discharge. The CoP (and many state licensing laws) do not include "assessment" as a duty of the LPN. The CoP can be read or downloaded from http://www.cms.hhs.gov/providers/hha/#oasis, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. The RN could not create an assessment as if it were fact without seeing a patient. In such a situation the RN did not inspect the patient's skin, observe the patient's performance of activities, or collect much of the non-OASIS data needed in a comprehensive assessment (e.g., vital signs, breath sounds, etc.). This makes evident some legal issues involved for the nurse and the agency. When a licensed clinician signs an assessment, he/she is attesting that the documentation contained therein is correct. It would be difficult to make such an assertion if the clinician signing the document had not

assessed the patient. Lastly, there is the issue of the agency's responsibility for managing patient care. When an agency admits a patient, the agency has a responsibility to ensure that a LPN's care is supervised by a RN. CoP 484.30(a) states that the "registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions..." This scenario is concerning because apparently the supervising RN did not know that the patient did not want further care or why. It would be important for the agency to evaluate the care and supervision provided. Were there truly no indications that the patient wanted or needed to be discharged? If such information had been reported to the RN, perhaps the RN could have completed a reassessment to determine if discharge or a change in care plan was appropriate. The agency would not know whether discharge was appropriate at this time or if there was another reason for the patient's request. In this situation, a registered nurse from the agency should complete a discharge assessment by visiting the patient.

For a more in-depth explanation of the rationale behind this response go to page 3768 (middle column) of the *Federal Register* posted January 25, 1999, where this was specifically addressed in the preamble to the statement of the Condition of Participation (CoP), 484.55. CMS pointed out that in the CoP (prior to 1999), patient evaluation is listed in the duties of the registered nurse at 484.30(a) and therapy services at 484.32, but not in the duties of the LPN at 484.30(b). Many State regulations also stipulate that patient evaluation and comprehensive assessment are duties of the registered nurse, not a licensed practical nurse. You can read or download the above-mentioned regulation in the *Federal Register* at http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage, scroll down to the heading, "OASIS Collecting and Reporting Regulations," and click on the link to view the final "collection" regulation.

HHAs who discover a large number of unplanned or unexpected discharges must be aware that retrospective data reporting can negatively impact the agency's outcome report in two ways: (1) the clinician's recall of patient status information is likely to be less accurate than the information recorded immediately upon assessment, and (2) the patient's status at time of discharge may actually be better (i.e., improved) than it was at the time of the visit conducted by the RN, PT, SLP, or OT. [Q&A EDITED 08/07]

Q38. I assume that a patient who is no longer receiving skilled care but continuing to receive personal care only will cease OASIS data collection at the end of skilled care. Is this correct? If it is, how should OASIS items M0100, M0870, and M0880 be answered in the discharge assessment?

A38. We encourage HHAs to complete a discharge assessment at a visit when a patient receiving skilled care no longer requires skilled care, but continues to receive unskilled care. While this is not a requirement, conducting a discharge assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's episode of care for purposes of the agency's outcome-based quality monitoring (OBQM) and improvement (OBQI) reports. Otherwise, that patient will not be included in the HHA's OBQM and OBQI statistics. It will also keep that patient from appearing on the HHA's roster report (a report you can access from your State's OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection. In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item

M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, it should also be marked.) We realize the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide only personal care services.

Q39. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat. 4b Q #21]

Q40. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat. 4b Q #16]

Q41. When a patient is transferred to a hospital, but does not return to the agency, what kind of OASIS assessment is required?

A41. No assessment is required at that point. The agency's last contact with the patient was at the point of transfer to the inpatient facility, so the transfer data conclude the episode from the point of OASIS data collection. If the agency had not already discharged the patient, there presumably would need to be some documentation placed in the clinical record to close the case for administrative purposes.

Q42. What should agencies do if the patient leaves the agency after the SOC assessment (RFA 1) has been completed and further visits were expected?

A42. Completion of a SOC Comprehensive Assessment is required, even when the patient only receives a single visit in an episode. Effective December 2002, there is no requirement to collect OASIS data as part of the comprehensive assessment for a single-visit episode. Some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.
If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q43. Since RFAs 2 and 10 were eliminated in December 2002, what should we do if only one visit is made at Resumption of Care? All the references I've seen address only the issue of one visit at SOC.

A43. Because the RFA 10 response originally stated, "after start/resumption of care," we advise you to follow the same instructions you would after only one visit at SOC (i.e., the ROC comprehensive assessment is required, but OASIS data collection is not required). No discharge comprehensive assessment or OASIS is required when no additional visits are made after the ROC visit. Agency clinical documentation should indicate that no additional visits occurred after the ROC assessment, and internal agency documentation of the discharge would be expected. You should be aware that the patient will continue to appear on the agency's roster report as an incomplete episode. The patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would get a warning that the new assessment was out of sequence. This will not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q44. What type of comprehensive assessment is required for pediatric, maternity, and patients requiring only personal care, housekeeping or chore services?

A44. All pediatric, maternity, and patients requiring only personal care, housekeeping or chore services are exempt from the OASIS data collection requirements. For pediatric, maternity, or personal care patients, the HHA will need to complete an agency-developed comprehensive assessment at the required time points. The agency may develop its own comprehensive assessment and tailor it to the needs of the patients of their case-mix. An HHA is not required to conduct a comprehensive assessment for individuals where HHA services are entirely limited to housekeeping or chore services. [Q&A edited 06/05]

Q45. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat 2 Q #39]

Q46. Home health patients may return to the hospital after a single visit. Some HHAs treat these as one-visit only episodes, do not collect OASIS data, and do not bill the Medicare program. Is this acceptable? In many instances, it appears that the patients were prematurely discharged from the hospital.

A46. Yes, this is acceptable. This scenario appears to fit the criteria for one-visit only episodes for Start of Care or Resumption of Care that became effective December 16, 2002. Each patient must receive a comprehensive assessment. The agency is not required to collect the OASIS items, nor encode and submit the assessment. This assessment can be placed in the clinical record for documentation and planning purposes.
[Q&A added 06/05] [Q&A EDITED 08/07]

Q47. For discharge assessments done on therapy-only cases (or when therapy is the last skilled service in the home), could a nurse visit the patient within 2 days of the therapy discharge and perform the comprehensive assessment? The date of discharge would be the date the therapist actually discharged the patient, while the date the assessment was completed (M0090) would be the date the nurse actually completes the comprehensive assessment.

A47. CMS regulations at 42 CFR 484.55(b) allow the therapist to conduct the discharge assessment at the discharge visit in either a therapy-only case or when the therapist is the last skilled care provider. If the agency policy is to have the RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge

assessment after the last visit by the therapist. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. The date of the actual discharge is determined by agency policy. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906 (Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted. [Q&A added 06/05]

Q48. If the RN is admitting and completing the initial and SOC comprehensive assessment for a Medicare case with orders for PT and home health aide (no nursing skill or orders), can the home health aide establish the SOC by making a visit on the same day as the RN admits. And if so, what time requirements would apply to when the PT must make his/her evaluation visit?

A48: The case as described is a therapy-only case, thus the RN or the therapist can conduct the initial assessment to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. Once patient eligibility has been confirmed, and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other covered home health services ordered in the plan of care. If a covered service is provided, the SOC date is established and the visit is Medicare billable. A start of care comprehensive assessment cannot be performed prior to the SOC date. Thus, in the situation described, the RN or the PT can make the initial assessment. However this is not a billable visit and should not be included in the therapy visits. The home health aide who provides a covered service can be the first billable (SOC) visit. If it is the HHA's policy for the RN to conduct the SOC assessment, this would follow the home health aide visit. The RN's SOC assessment should be completed on or within five days after the SOC date (or according to agency policy). The timing of the PT evaluation visit is not specifically defined by the Conditions of Participation, except to say that the practice must comply with accepted professional standards and principles. Reference: Interpretive Guidelines G336 [Q&A ADDED 08/07 Previously CMS OCCB 03/05 Q&A #1]

Q49. When initial orders exist for nursing and PT, can the PT make an evaluation visit and establish the start of care, with the RN subsequently visiting to conduct the initial assessment visit and to complete the SOC comprehensive assessment?

A49: No. When initial orders exist for nursing and PT, the Conditions of Participation require that the RN conduct the initial assessment visit to determine the immediate care needs of the patient, and for Medicare patients, to establish program eligibility including homebound status. When nursing orders are present at the SOC, the RN is allowed up to five days after the SOC date to complete the SOC comprehensive assessment. The PT may conduct the PT evaluation visit after the initial visit by the RN and during the five-day period while the SOC comprehensive assessment is completed. Reference: Interpretive Guidelines G331 [Q&A ADDED 08/07 Previously CMS OCCB 03/05 Q&A #2]

Q50. One of the time requirements outlined in the CoPs for the initial assessment visit is that it must be conducted "within 48 hours of referral". Does "referral" mean referral from a physician, or referral from anyone (e.g., the patient, family,

assisted living facility)? Sometimes when we are contacted by the patient or family member, physician's orders for home care may not exist. Does the "clock" for the 48 hours start when the patient/family contacts the agency requesting services, or when the physician provides orders?

A50: "Referral" refers to the referral from a physician (or designee) for home care evaluation and/or services. The referral may come in the form of initial contact by the physician's office, a hospital discharge planner or even the patient or family member, who may be in possession of the written physician's orders for home care.

If a patient or family member makes initial contact with the agency and has not discussed and/or received home care orders from the physician for a referral for home care, then this is not considered a "referral" for the purposes of determining compliance with conducting the initial assessment visit. In this case, the agency should contact the physician to obtain necessary orders, and then conduct the initial assessment visit within 48 hours of that referral, within 48 hours of the patient's discharge from an inpatient facility, or on the physician's ordered start of care date. [Q&A ADDED 08/07; previously CMS OCCB 07/06 Q&A #1]

Q51. Start of Care visit - If both nursing and therapy are ordered at SOC, does the RN have to visit the patient before the therapist? If this is required and the PT visits before the RN, what is the impact on the agency?

A51: The Condition of Participation, 484.55, Comprehensive Assessment of Patients found at www.access.gpo.gov/su_docs/fedreg/a990125c.html stipulates that a registered nurse must conduct the initial assessment unless it is a therapy only case. Since "initial" means first, when nursing orders exist at Start of Care, the RN must be the first person to see the patient and complete the initial assessment requirements.

The Conditions also require that if nursing orders exist at SOC, the RN must complete the SOC comprehensive assessment including the OASIS. This does not necessarily mean that the SOC comprehensive assessment must be completed by the RN on the SOC date or that the initiation of therapy must be delayed until the RN completes the comprehensive assessment. Federal guidelines state the SOC comprehensive assessment including the OASIS must be completed within 5 days after the SOC date. (See the OASIS Assessment Reference Sheet, http://www.cms.hhs.gov/OASIS/Downloads/OASISRefSheet.pdf). Of course, if your agency policies are more restrictive (e.g., require earlier completion), you must follow your policy.

You also asked what is the impact to the agency if the PT visits the patient before the RN when both nursing and PT are ordered at SOC. Your agency will be out of compliance with the Medicare Conditions of Participation when you allow the therapist to make the initial assessment visit when there are also nursing orders. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #2]

Q52. First scenario: A home care agency receives an order for RN and PT for a patient. The SN does the SOC OASIS assessment on the first billable visit of 1/1/07. The Physical therapist does his initial eval on 1/3/07 and upon review of the RN's SOC OASIS documentation, it is discovered that the patient's functional status documented on the OASIS differs from the PT evaluation.

Should the PT discuss his findings with the RN and, if agreed upon, make changes to the SOC OASIS completed on 01/01/07? Does another visit have to occur jointly? Is there a certain time frame this can happen?

A52: While the comprehensive assessment must be completed by only one clinician, it is an excellent idea for all the disciplines caring for a patient to discuss assessment findings and their plans of care. The RN who performs the SOC comprehensive assessment on the SOC date, 1/1/07, has up to 5 days after the SOC (the date of the first billable visit) to complete the SOC OASIS assessment. When conferring with the PT regarding his 1/3/07 visit assessment findings, the RN may discover the SOC OASIS responses chosen do not reflect the assessment findings of the therapist. The RN and PT should further discuss the patient's status to determine if:

1) The differences noted in the patient's status or ability would be considered **normal progression of disease or recovery based on the time that lapsed** between the two assessments, (e.g. the RN noted the patient required assistance of another at all times to ambulate on 1/1/07 due to weakness after hospital discharge. The PT conducted his evaluation on 1/3/07 and the patient's weakness had greatly improved and only needed supervision of another to ambulate at night when she was tired.) In this case, the differences noted can be attributed to normal progression of recovery and do not indicate that the 1/1/07 findings were necessarily inaccurate.

2) The differences noted in the patient's status were due to a **misunderstanding of the OASIS scoring guidance**, (e.g. the RN believed that M0680 Toileting included the patient's ability to transfer on and off the toilet and clothing management.) After discussion, if the RN believes her original score was inaccurate because she inappropriately applied her assessment findings when selecting an OASIS response, changing her response to M0680 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.

3) The differences noted were due to a **difference in the interpretation of assessment findings**, (e.g. The RN observed the patient ambulating while holding onto furniture and walls and believed the patient was independent and needed no assistance. The PT made the same observation but understood the walls and furniture represented the patient's need for assistance for safe ambulation.) If after discussion, the RN believes her original score was inaccurate because she inappropriately interpreted her assessment findings, changing her response to M0700 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.

4) The differences noted were due to a **difference (or adequacy) in the assessment approach**, (e.g. The RN asked the patient if he could dress himself. The PT asked the patient to demonstrate gathering his clothes and putting on and removing select clothing items.) The RN should not base or change her assessment scores based solely on the assessment of the PT, if such assessment findings were not observed by the RN. If after discussion the RN questions the accuracy of her score because she believes she may not have gathered sufficient information necessary to determine the patient's ability to dress, the RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed.

Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed.

5) The differences, after discussion, **cannot be reconciled**. The RN's observations are not consistent with the PT's evaluation. The RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed. Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #3]

Q53. A patient is recertified on 2/21/07 for a new cert period starting 2/26/07. The patient goes into the hospital on 2/23/07 and is discharged from the hospital on 2/26/07. We go back out to see her on 1st day of new episode 2/26/07. Would she require a ROC or a SOC OASIS?

A53: Special guidance applies when the patient returns home from the inpatient facility on day 60 or 61. You will need to complete the ROC assessment and then make a decision based on the HIPPS code. If it did not change from the recert assessment, then you submit the ROC, as it is considered a continuous episode. If the HIPPS code did change from the recert assessment, home care would not be considered continuous and you would perform a "paper billing" discharge and then submit the assessment as a SOC. More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf (see excerpt below)

> **"2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61**
> A hospital discharge may occur on day 60 or day 61and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit "same-day transfers" among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 reflected day 61. The RAP would not report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary's admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 that reflected the first date of service provided after the hospital

discharge. The RAP would also report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency." [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #4]

Q54. For a Medicare patient, a recert visit is done April 16th, which was the last day of the first cert period. The patient is hospitalized on April 18th, the second day of the new cert. No home care visits were provided in the new cert period before the hospitalization. Which assessments should be completed and is discharge required?"

A54: If the Medicare PPS patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new episode, the agency should complete a transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency may select RFA 6 or 7, depending on agency policy and practice.

If the agency selects RFA 7, then when the patient returns to home care services, a new SOC should be completed.

If the agency selects RFA 6, then when the patient returns to home care services within the episode, a SOC/ROC comprehensive assessment should be completed. In order to determine if this assessment should be reported as a SOC or a ROC, the HHRG/HIPPS code resulting from the assessment responses should be determined. If the resulting HHRG/HIPPS code is the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes are considered continuous. In this case the assessment should be reported as a ROC, no discharge is required, and the care continues on under the original certification periods. This is an example of a situation in which the first visit in a new certification period could be the Resumption of Care visit.

If the resulting HHRG/HIPPS code is not the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes would not be considered continuous. In this case the patient should be discharged through completion of agency discharge paperwork or process, and the new assessment should be reported as a SOC, establishing a new episode with a new certification period. All assessments completed (the SOC and recertification assessments completed in the previous episode, the transfer, and the SOC or ROC assessment in the next episode) should be transmitted to the State Agency. A discharge OASIS assessment under the previous episode is not required, and if the home health agency completed an RFA 6 upon transfer and the episodes were eventually determined to not be continuous (under the conditions explained above), the agency does not need to "correct" the RFA 6, (by changing to an RFA 7, indicating discharge). The submission of the assessment sequence (SOC RFA 1, Recert RFA 4, Transfer RFA 6, SOC RFA 1...) will be accepted by the State Agency, and the documentation contained within the clinical record(s) should clarify the events.

More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf, (see excerpt below)

3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care. The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #5]

Q55. In the new Q&As that were posted in May 2007 it states that if an agency has done a recert and then the patient goes to the hospital and the agency does a transfer without dc, then when the patient comes back the clinician does the comprehensive assessment. Depending on the HIPPS code would depend on if they did a ROC or a SOC. But what if the agency had not done the recert and the patient went to the hospital on day 58. When the patient comes out would they do a new SOC? (Since there is no HIPPS code to match up with).

A55: If a patient is transferred to the hospital on day 58, before the recertification assessment was completed, and the stay in the inpatient facility met the criteria for a Transfer, the agency would complete a Transfer OASIS. When the patient returns home, if it is on 59 or 60 and they have not been discharged from the home care agency, a Resumption of Care (RFA 3) assessment would be completed, and would satisfy both the ROC and the recertification requirements. If the patient's stay extends beyond the end of the current certification period, a SOC would be completed. The agency would also need to perform a "paper" discharge from the previous episode, (no OASIS DC required). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #3]

Q56. If a patient converts to a payer requiring a new SOC, is it OK to do the SOC OASIS on next visit (under the new pay source) even if that visit isn't scheduled for up to a week after the last visit under the old payer?

A56: When a patient is changing pay sources to a payer which requires a new SOC, then the agency must provide an initial assessment visit within 48 hours of the time of referral or on the physician's ordered Start of Care date. If the orders for the new episode are for SN to begin on a date a week away, then the initial assessment visit and SOC Comprehensive Assessment may be completed one week after the discharge visit under the old pay source, if that meets the physician's ordered start of care date. Alternatively, the agency may have completed the initial assessment requirements (determined immediate care and support needs, and eligibility for the home health benefit if appropriate) at the last visit under the old pay source, in which case the SOC comprehensive assessment may still be conducted at the next visit (in a week), noting that if the patient were to develop problems and require services in between the visits,

the SOC may need to be completed sooner. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #1]

Q57. Has there been any regulatory changes that prohibit a nurse from doing the initial SOC OASIS if only therapy is ordered?

A57: There have not been any regulatory changes to the Condition of Participation (CoPs), 484.55, Comprehensive Assessment of Patient Standard (a) Initial assessment of patients. But the Standard does not prohibit a nurse from performing the initial assessment visit when there are therapy only orders. It states that the RN must complete the initial assessment visit when nursing orders exist at SOC. If there are therapy only orders, no nursing at all, the appropriate therapist may complete the initial assessment visit. Agencies are at liberty to develop policies that are more restrictive than the CoPs (e.g., policies that allow or require the RN to perform the initial assessment visit during a non-billable visit when there are no nursing orders at SOC). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #2]

Q58. Medicare patient goes to hospital, agency completes RFA 6, Transfer, patient not discharged. Patient returns home with orders for one PT visit to evaluate new equipment. PT does eval and determines no further visits are necessary. Should HHA complete ROC, even though no further visits are going to be provided? And if the HHA completes the ROC, would they complete a DC on the same day?

A58: In responding to the question, it will be assumed that the single PT visit conducted at the resumption of care was a skilled and covered visit, that the resumption of care visit occurred within the existing 60-day episode, and that we are discussing a Medicare PPS patient.
A comprehensive assessment must be completed when the patient returns home from an inpatient stay of 24 hours or greater for any reason other than diagnostic tests, even though there will only be the one PT visit. The Conditions of Participation 484.55 Comprehensive Assessment of Patients, Standard (d) states:
The comprehensive assessment must be updated and revised within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.
However, since 2002, OASIS is not a required part of the comprehensive assessment for known one-visit patient episodes. CMS Q&A Cat 2 Q43 clarifies that a ROC comprehensive assessment is required, even if it is the only visit conducted after the inpatient discharge, but that the assessment should be treated like a one-visit only episode at the start of care (i.e., comprehensive assessment is required, but OASIS data collection is not required). While there is not a regulatory requirement to collect OASIS as part of these assessments, there may be a reimbursement requirement by the payer to do so.
No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]

CATEGORY 3 - FOLLOW-UP ASSESSMENTS

Q1. When is a recertification (follow-up) assessment due for a Medicare/Medicaid skilled care patient?

A1. A Medicare/Medicaid skilled-care adult patient who remains on service into a subsequent episode requires a follow-up comprehensive assessment (including OASIS items) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged. [Q&A EDITED 08/07]

Q2. What are the requirements for follow-up comprehensive assessment for pediatric and maternity patients where the payer is Medicaid?

A2. Pediatric and maternity patients have been exempt from the OASIS data collection requirements; however, the agency must still perform a follow-up comprehensive assessment at any time up to and including day 60. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. The agency may develop its own comprehensive assessment form for these clients. Clinicians may perform the follow-up comprehensive assessment more frequently than the last 5 days of the 60-day episode without conducting another comprehensive assessment on day 56-60, and remain in compliance with § 484.55(d). [Q&A EDITED 08/07]

Q3. A patient is hospitalized and comes back to the agency on day 56. Which assessment do we complete? A resumption of care (ROC) or follow-up (FU) or do we need to do both?

A3. When the patient returns to the agency during the last 5 days of an episode, the ROC assessment should be completed, fulfilling both the ROC and recertification requirements. M0826 should forecast therapy use for the upcoming episode. You can find the instructions (mentioned above) for handling this type of situation in the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website
https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf

Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf; scroll to page 94 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI.
[Q&A EDITED 08/07]

Q4. [Q&A RETIRED 08/07; Outdated.]

Q5. Must both a recertification and a Resumption of Care (ROC) assessment be completed when a patient returns to the agency from an inpatient stay a day or two before the last 5 days of a payment episode?

A5. In your example, if the patient were discharged from the inpatient facility on day 53, the agency would be required to complete a ROC assessment no later than day 55 and

a recertification assessment within days 56-60, because the regulations require that the ROC assessment be done within 2 days of the discharge from the inpatient facility.

If the patient were discharged from the inpatient facility on day 54 or 55, the ROC assessment could be done on day 56 or 57, respectively (providing the physician was in agreement). In that case, refer to the answer to Q3 in this category.

Q6. Please clarify the 60-day certification period referred to in the regulations. Hasn't CMS been flexible in allowing a shorter certification period if the patient's condition changed?

A6. Collecting uniform data on patients at uniformly defined time points means that certification periods will need to be less flexibly defined. Therefore, HHAs must adhere to a 60-day certification period, based on the SOC date. The HAVEN data specifications have been developed according to this schedule, and agencies will be in compliance with the regulations if they adhere to this schedule.

Q7. Should my agency be concerned about 'counting out' 60-day intervals in order to schedule the follow-up assessment?

A7. To assist agencies determine the correct 60-day time frame for scheduling OASIS follow-up assessments, go to the QIES Technical Support Office website https://www.qtso.com/download/hha/oasiscal2007.pdf and download 'Scheduling OASIS Follow-up Assessment' under OASIS. There you will find the current year calendar in pdf file, which will help you determine a patient's first, second and third certification periods based on the start of care date. [Q&A EDITED 08/07]

Q8. Is it necessary to make a visit in order to complete the follow-up reassessment?

A8. Yes, the follow-up comprehensive assessment must be performed in the physical presence of the patient. A telehealth interaction does not constitute an in-person visit for the purposes of completing the required comprehensive assessment. [Q&A EDITED 08/07]

Q9. If a clinician's visit schedule is 'off track' for a visit in the last 5 days of the 60-day certification period, can a visit be made strictly for the purposes of doing an assessment? Will this visit be reimbursed by Medicare?

A9. Under PPS, a visit can be made for only the purpose of performing an assessment, but it will not be considered a billable visit unless appropriate skilled services are performed. A recertification assessment not completed during the appropriate time frame raises a number of issues, including non-compliance with home health conditions of participation (CoP), a potential likelihood of a visit made without physician's orders, and payment related issues for Medicare PPS patients. Although it is not explicitly spelled out in the CoP, the expectation that accompanies the requirement to update the comprehensive assessment between days 56 & 60 is that the orders for the ensuing 60 days will be based on the results of that assessment. The patient's care orders essentially expire at the end of day 60, so day 61 begins a new payment episode. If the patient is a Medicare patient, you should discuss any payment-related issues with your Regional Home Health Intermediary (RHHI).

Q10. What if the patient refuses a visit during the 5-day recert window?

A10. Most patients are willing to receive a visit if the visit schedule and required time points have been explained to them during the episode. In addition, PPS requires a visit during the same 'window' for the agency to receive continued reimbursement for a specific Medicare patient. If the HHA is completely unable to schedule a visit during this period, the follow-up assessment should be completed as soon after this period as possible.

Although it is not explicitly spelled out in the COP, the expectation that accompanies the requirement to update the comprehensive assessment between days 56 & 60 is that the orders for the ensuing 60 days will be based on the results of that assessment. The patient's care orders essentially expire at the end of day 60, so day 61 begins a new payment episode. The agency should be aware of potential legal issues associated with completing the assessment late, considering that the agency may not have orders for visits after the end of the 60-day period. If the patient is a Medicare patient, you should discuss any payment-related issues with your Regional Home Health Intermediary (RHHI). [Q&A EDITED 08/07]

Q11. If an agency misses the recertification assessment window of day 56-60, yet continues to provide skilled services to the Medicare patient, is the agency required to discharge and readmit the patient? Or, could the agency conduct the RFA 4 assessment late? Will any data transmission problems be encountered?

A11. When an agency does not complete a recertification assessment within the required 5 day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date the assessment is completed, with documentation in the clinical record of the circumstances surrounding the late completion. A warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. Obviously, this situation should be avoided, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's RHHI. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #1] [Q&A EDITED 08/07]

Q12. What are the indications for an 'other follow-up' (RFA 5) assessment?

A12. In the preamble to the comprehensive assessment regulation, it is noted that a comprehensive assessment with OASIS data collection is required when there is a major decline or improvement in health status. Each agency must determine its own policies regarding examples of major decline or improvement in health status and ensure that the clinical staff is adhering to these policies. In the event the agency determines that an assessment at a point in time not already required is necessary (based on its own policies), reason for assessment (RFA) #5 under M0100 would be selected. [Q&A EDITED 08/07]

Q13. If a resumption of care assessment is performed, does the clock 'reset' with respect to follow-up assessment, i.e., is the follow-up due 60 days after resumption of care or does it remain 60 days from the original start of care date?

A13. Unless the patient has been discharged, the due dates for follow-up assessments are calculated from the original start of care date rather than from the resumption of care date. For additional guidance on transferring patients with or without discharge and resuming care, see the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf

Q14. Our agency has a custodial service program that provides personal care and patients remain on service for several years. How do we determine the reassessment date?

A14. Note that the certification periods and the recertification follow-up assessment window are ALWAYS calculated relative to the start of care date.

Q15. [Q&A DELETED 08/07; Question focus was Physician's Orders. Refer to State Survey Agency for guidance.]

Q16. Since OASIS is temporarily suspended for non-Medicare/non-Medicaid patients, must I complete the Follow-up assessment at day 56-60?

A16. For the non-Medicare/non-Medicaid patient, the assessment may be performed any time up to and including the 60th day. The timetable for the subsequent 60-day period would be measured from the completion date of the most recently completed assessment. Another way of stating this clarification is that clinicians may perform the comprehensive assessment more frequently than the last 5 days of the 60-day period without conducting another assessment on day 56-60, and remain in compliance with 484.55(d).

Q17: I am trying to find clarification on how to use RFA 5 for decline or improvement. When I review the OASIS time points, it lists RFA 5 as a SCIC with or without hospitalization. Does the RFA 5 only have to be done when payment is affected? If the patient improved, I would think we would be discharging, thus RFA 9. I don't understand what RFA 5 is used for.

A17: When the patient experiences an event that meets your agency's definition of a major decline or improvement in the patient's health status, you are required to complete the RFA 5, the Other Follow-up assessment, in order to be compliant with the Medicare Conditions of Participation – Section 484.55(d). In the preamble to the comprehensive assessment regulation, 484.55, it is noted that a comprehensive assessment (with OASIS data collection, if applicable) is required when there is a major decline or improvement in health status. CMS encouraged each agency to develop its own guidelines and policies for this type of assessment and did not provide written requirements about what constitutes a significant decline or improvement.

This requirement to complete an RFA 5 for a patient experiencing a major decline or improvement in health status should not be confused with the Significant Change in

Condition (SCIC) payment adjustment which was introduced in the initial Home Health Prospective Pay System (PPS) model. Regardless of the pay source or impact, current regulations require that any patient experiencing a major decline or improvement (as defined by your agency) is expected to receive a follow-up comprehensive assessment. Following agency policy, if the clinician identifies that there has been a major decline or improvement, the clinician will complete the assessment and evaluate the plan of care and modify as needed.

You stated that if a patient had a major improvement, you would discharge, but that may not be true if the patient had continuing home care needs. For example, if your patient had a CVA and at SOC and subsequently experienced a significant resolution of neurological symptoms, this patient may meet the criteria for your agency's definition of a major improvement. If the patient continued to have nursing needs related to medication management, you may not discharge until those goals were met. The RFA 5 would serve as the vehicle to reassessment the patient's status after the major change in status. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #6]

CATEGORY 4 - OASIS DATA SET: FORMS and ITEMS

Category 4A - General OASIS forms questions.

Q1. Will there be any further revisions to the OASIS-B1 data set currently posted on the OASIS website?

A1. The most current version of the OASIS data set will always be available on the OASIS website http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage. When revisions are necessary in the future, we will post them on the website well in advance of their effective dates. [Q&A EDITED 08/07]

Q2. When integrating the OASIS data items into an HHA's assessment system, can the OASIS data items be inserted in an order that best suits the agency's needs, i.e., can they be added in any order, or must they remain in the order presented on the OASIS form?

A2. Integrating the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set would facilitate data entry of the items into the data collection and reporting software. However, it is not mandatory that agencies do this. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the State. As long as the agency can format the required CMS data submission file for transmission to the State agency, it doesn't matter in what order the data are collected.

Q3. Are agencies allowed to modify skip patterns through alternative sequencing of OASIS data items?

A3. While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items EXACTLY as they are written into their own assessment instrument. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function (HAVEN) prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. HAVEN includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than HAVEN to report their data so as long as the data are ultimately presented to the State agency in the required CMS data submission format found on the CMS Website at http://www.cms.hhs.gov/oasis/04_dataspecifications.asp. This file that contains the OASIS data items in the same order as contained on the OASIS data set. [Q&A EDITED 08/07]

Q4. Are any quality assurance tools available to help us verify that our staff is using the OASIS correctly?

A4. We are not aware of any standardized quality assurance tool that exists to verify that clinical staff members are using OASIS correctly. A variety of audit approaches might be used by an agency to validate the appropriate responses to OASIS items. For example, case conferences can routinely incorporate OASIS items as part of the discussion. Multi-discipline cases with visits by two disciplines on adjacent days can contribute to discussion of specific items. (Note that only one assessment is reported as the 'OASIS assessment.') Supervisory (or peer) evaluation visits can include OASIS data collection by two clinicians, followed by comparison of responses and discussion of any differences. Other approaches to data quality monitoring are included in the *OASIS User's Manual*, Chapter 12 available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. [Q&A EDITED 08/07]

Q5. How do I cut and paste the OASIS questions on the website into our HHA's own assessment?

A5. We have posted the OASIS data set in both .PDF format, i.e., read only format, and Word format on the OASIS Data Sets page at http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage. [Q&A EDITED 08/07]

Q6. Do you have anything available that would help us integrate the OASIS items into our own assessment?

A6. The most current version of OASIS will be found on the CMS OASIS website. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the M0xxx numbers when integrating to alert clinicians that the M0xxx labeled items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Please refer to Appendix C of the *OASIS User's Manual* (available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp) for examples of a comprehensive assessment (sample clinical records) showing an integration of the OASIS data items with other agency assessment items for each time point. The OASIS data sets are available in Appendix B in the *OASIS User's Manual* or on the OASIS Data Sets page at http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage. [Q&A EDITED 08/07]

Q7. Is there a separate OASIS admission form that can be used for rehab-only cases where skilled nursing is not involved?

A7. The sample assessment forms (incorporating OASIS items) found on the OASIS Data Sets page http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage most closely resemble nursing assessments. CMS does not have sample rehab

assessment examples, though such assessments have been developed by commercial vendors. If an agency chooses to develop its own rehab-specific assessment forms, the principles for documenting OASIS items into an agency's clinical documentation are outlined in Chapters 4 and 7 of the *OASIS User's Manual* available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. [Q&A EDITED 08/07]

Q8. The start of care (SOC) version of OASIS posted on the OASIS web site shows the description of M0550 with two definers, a) and b). However, the Discharge version does not show both definers. Should the definers be included at all assessment time points?

A8. The a) definer (related to an inpatient stay) is specific to SOC (or resumption of care after an inpatient stay), and Follow-up assessment time points. It is not appropriate for the Discharge and therefore is omitted from that time point version. The data set instructs "*At discharge, omit references to inpatient facility stay." [Q&A EDITED 08/07]

Q9. Are the OASIS data sets (all time points) to become part of the patient's record? Do we keep them in the charts? Of course, our admission OASIS data set will be part of the chart because we have our admission assessment included in the OASIS questions. But with the ROC, Transfer, DC, do we make this part of the record?

A9. The Comprehensive Assessment Final Rules, published January 25, 1999, state that the OASIS data items are to be incorporated into the HHA's own assessments, not only for the start of care, but for all the time points at which an update of the comprehensive assessment is required. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record. Verifying the accuracy of the transmitted OASIS data (part of the condition of participation [CoP] on Reporting OASIS information) requires that the OASIS data be retained as part of the clinical documentation. To access the CoP, go to http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q10. If the OASIS data elements are being filled out for the Start of Care, Follow-up and Discharge, is there an additional nursing note required as a Federal regulation? Or is an additional nursing note (as a summary of data gathered) not required, assuming the OASIS elements include all necessary patient information?

A10. As noted in CFR §484.55 (the condition of participation [CoP] regarding comprehensive assessment), "each patient must receive a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." The preamble to this rule also notes that the OASIS data set is not intended to constitute a complete comprehensive assessment. Each agency must determine, according to their policies and patient population needs, the additional assessment items to be included in its comprehensive assessment forms. Clinical notes are to be completed as required by 42 CFR 484.48 and the home care agency's clinical policies and procedures. To access the CoP, go to

http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q11. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat. 2 Q #7]

Q12. In some places in the OASIS User's Manual, the prior 14 days is referred to as being a 'point in time' and in other places, it is referred to as a 'period of time'. Are the '14 days prior' assessment items to be based on what the patient was doing on the 14th day prior to the assessment or on what the patient could usually do the majority of the time during the 14-day period prior to the assessment?

A12. In the ADL/IADL data items (M0640 through M0800), the patient's ability 14 days prior to the start (or resumption) of care is addressed. In these items, 'prior' indicates the patient's status on the 14th day before the start (or resumption) of care. Adhere strictly to this 14-day time point. If the patient was in a hospital at that time, describe the patient's ability on that day. Several other OASIS items (e.g., M0170, M0200, etc.) address events that may have occurred within the last 14 days. In responding to those items, the entire 14-day period should be considered. For example, was the patient discharged from an inpatient facility during the span of 14 days? [Q&A EDITED 08/07]

Q13. There seems to be a discrepancy between the instructions in the OASIS User's Manual regarding M0890, M0895, and M0900. In Appendix B, these three items are omitted from the discharge assessment, yet the items are included in the Inpatient Transfer with Discharge grouping. Should these items be included in the discharge assessment?

A13. The answer to this question depends on whether your agency uses separate assessment forms for Transfer to an Inpatient Facility and for Discharge (not to an inpatient facility). If it has separate forms, these three data items should be included in the assessment for Transfer to Inpatient Facility and not included in the Discharge assessment. On the Transfer to an Inpatient Facility, these items are included in the list of assessment items to be completed. Under Discharge from Agency - Not to an Inpatient Facility, these items are correctly not included. If your agency uses only one form that includes both Transfer and Discharge, however, these items should be included, with notation directing the assessing clinician to only collect these and Transfer (RFA 6 or 7) and not at Discharge (RFA 9). [Q&A EDITED 08/07]

Q14. Our agency has created separate clinical documentation forms for Transfer to Inpatient Facility and for Discharge. On our Discharge form, we omitted M0890, M0895, and M0900 according to the web site information. Yet, when a clinician answers 'hospital' for M0855 on the Discharge form, she is directed to skip to M0890 (which is not included). What should happen in this scenario?

A14. Because your agency has a separate clinical form for Transfer to Inpatient Facility, the clinician should NOT be marking 'hospital' on the Discharge form (for M0855) because a discharge assessment is not correct at the time of transfer. Instead, the clinician should be using the Transfer form, which will direct her/him from M0855 to M0890 when 'hospital' is marked on that form. (M0890, M0895, and M0900 are all included in the Transfer data items.) For HHAs with separate Transfer and Discharge forms, the only correct response to M0855 on the Discharge form is 'NA - No inpatient facility admission.' This is an excellent training reminder to share with your staff.

Q15. [Q&A RETIRED 08/07; Outdated]

Q16. [Q&A DELETED 01/08 due to changes in OASIS data set and skip patterns at follow-up (RFA 4,5)].

Q17. Unless otherwise indicated, scoring of OASIS items is based on the patient's status on the "day of the assessment." Does the "day of the assessment" refer to the calendar day or the most recent 24- hour period?

A17. Since home care visits can occur at any time of the day, and to standardize the time frame for assessment data, the "day of the assessment" refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient's ability and status, regardless of the time of day of the visit. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #1] [Q&A EDITED 08/07]

Category 4B - OASIS Data Items

Q1. PTS. Can the Patient Tracking Sheet be combined with another form such as the agency's referral form?

A1. The agency may choose to use the Patient Tracking Sheet as any other clinical documentation, integrating additional items as desired. If the agency typically collects other items at SOC and updates them only as necessary during the episode of care, these items might be good choices to integrate with the other Tracking Sheet items. The patient's telephone number might be an example of such an item.

Q2. PTS. Can other (agency-specific) items be added to the Patient Tracking Sheet?

A2. The agency can incorporate other items into the Patient Tracking Sheet (PTS) as needed for efficient care provision. Examples of such items that would "fit" nicely with the OASIS PTS items would be the patient's street address, telephone number, or directions to the patient's residence.

Q3. PTS. Must the clinician write down/mark every single piece of information recorded on the Patient Tracking Sheet (e.g., could clerical staff enter the address, ZIP code, etc.)?

A3. Consistent with professional and legal documentation principles, the clinician who signs the assessment documentation is verifying the accuracy of the information recorded. At the time of referral, it is possible for clerical staff to record preliminary responses to several OASIS items such as the address or ZIP code. The assessing clinician then is responsible to verify the accuracy of these data.

Q4. What do the "M000" numbers stand for?

A4. The "M" signifies a Medicare assessment item. The following four characters are numbers that identify the specific OASIS item.

Q4.1. M0010 & M0072

1. **As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?**
2. **And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?**

A4.1: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or "CCN"). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it can be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may require NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number.

Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions; they simultaneously use it to report the Primary Referring Physician ID in M0072. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #8]

Q5. M0016. What do I enter in M0016 Branch ID after January 1, 2004 if I am an HHA with no branches, a parent, a subunit, or a branch?

A5. If you are a HHA with no branches, please enter "N" followed by 9 spaces. If you are a parent HHA that has branches, please enter "P" followed by 9 spaces. If you are a subunit with no branches, please enter "P" followed by 9 spaces. If you are a branch, enter the Branch ID number assigned by the Regional Office (RO). The Branch identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS assigned branch number.

Q6. M0030. Is the start of care date (M0030) the same as the original start of care when the patient was first admitted to the agency, or is it the start of care for the current certification period?

A6. The start of care date (M0030) is the date of the first reimbursable service and is maintained as the stare of care date until the patient is discharged.. It should correspond to the start of care date used for other documentation, including billing or physician orders. [Q&A EDITED 08/07]

Q7. M0030. What if a new service enters the case during the episode? Does it have a different SOC date?

A7. There is only one Start of Care date for the episode, which is the date of the first billable visit.

Q7.1. M0030. Related to M0030, the 06/06 revisions to Chapter 8 of the OASIS Implementation Manual, have redefined the SOC date to be the day of the first skilled visit. The revisions substituted "skilled" for "reimbursable". Does this mean that once need and eligibility is established, aide visits provided before the first skilled visit are not included in the episode of care? For instance, if PT and HHA are ordered, and a registered nurse does a non-billable initial assessment visit to establish needs and eligibility for a therapy only patient, can't the home health aide make a "reimbursable" visit prior to the day the therapist makes the first "skilled" visit for a Medicare patient? And wouldn't the aide's visit establish the SOC?

A7.1: CMS Q&A, Category 2, Question 36 clarifies that the "start of care" is defined as the first billable visit. The change in language found on page 8.18 of the 06/06 revision to Chapter 8 of the OASIS Implementation Manual, where the word "reimbursable" was replaced with "skilled" was unintentional and providers are instructed to continue to define the Start of Care as the date the first covered or reimbursable service is provided.

It is possible that the visit that establishes the SOC is not skilled, as in the scenario presented in the question above where the aide's visit is both reimbursable and establishes the start of care for the episode. The Conditions of Participation 484.55, Comprehensive Assessment of Patients Interpretive Guidelines states "For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide." More recent instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services) does state that now, even for Medicare, the first billable visit might be a visit made by a home health aide, once the need and eligibility has been established. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #7]

Q8. M0032. How should resumption of care (ROC) be documented if it occurred in a previous 60-day episode/ certification period? What if the latest resumption of care (ROC) was in a previous 60-day episode?

A8. The most recent ROC should be documented, even if it was in a previous 60-day payment episode, as long as the patient has not been discharged from the agency since the most recent ROC.

Q9. M0040. On M0040, the manual lists the name requirement as 'First, MI, Last, Suffix' but the HAVEN software requires 'Last, First, MI, Suffix.' Can we change the order on our forms to match the software?

A9. Yes.

Q10. M0063. If the patient has Medicare, but Medicare is not the primary pay source for a given episode, should the patient's Medicare number be entered?

Q10. The patient's Medicare number should be entered, whether or not Medicare is the pay source for the episode. Keep in mind that Medicare is often a secondary payer, even when another payer will be billed first. In order to bill Medicare as a Secondary Payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150, even though the patient's Medicare number is reported in M0063. [Q&A EDITED 08/07]

Q11. [Q&A DELETED 08/07; Replaced by updated Q&A.]

Q12. M0072. For M0072, are you requesting the ID of the physician who sent the referral or the ID of the primary physician responsible for the patient and who will sign the Plan of Care? They may be different.

A12. If these are different, you should use the same physician information used for filing Medicare (or other) claims to complete M0072. This should be the ID of the physician who signs the plan of care.

Q12.1. M0010 & M0072

3. **As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?**
4. **And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?**

A12.1: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or "CCN"). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it can be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may require NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number.

Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions; they simultaneously use it to report the Primary Referring Physician ID in M0072. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #8]

Q13. M0080. Why are Social Workers not included on OASIS item M0080?

A13. In item M0080 - Discipline of Person Completing Assessment, you will find the initials of clinicians (RN, PT, SLP/ST, OT) who can initiate a qualifying Medicare home health service and/or are able to complete the assessment. Social workers are not able to initiate a qualifying Medicare home health benefit or complete the comprehensive assessment, but may support other qualifying services. In the Medicare Conditions of Participation (CoP), CFR 484.34, conducting a comprehensive assessment of the patient is not considered a service that a social worker could provide. To access the CoP, go to http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q14. M0090. We have 5 calendar days to complete the admission/start of care assessment. What date do we list on OASIS for M0090 - Date Assessment Completed when information is gathered on day 1, 3 and 5?

A14. Generally, you would enter the last day that assessment information was obtained on the patient in his/her home, if all clinical data items were completed. However, if the clinician needs to follow-up, off site, with the patient's family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last bit of information is collected. [Q&A EDITED 08/07]

Q15. M0090. We had a patient admitted to the hospital on April 15 and found out about it on April 19. When we enter the transfer (patient discharged) assessment (M0100 reason for assessment 7) into HAVEN, we get a warning message that the record was not completed within correct timing guidelines. (M0090) date should be no earlier than (M0906) date AND no more than 2 days after M0906 date.

A15. That message is intended to be a reminder that you should complete a transfer assessment within 48 hours of learning of it. The regulation states that the assessment must be completed within 48 hours of learning of a transfer to an inpatient facility, so in this case, the assessment has been completed in compliance. The warning does not prevent the assessment from being transmitted. If you find that this warning occurs consistently, you may want to examine whether your staff are appropriately tracking the status of patients under their care. [Q&A EDITED 08/07]

Q16. M0090. Is the date that an assessment is completed, in M0090, required to coincide with the date of a home visit? When must the date in M0090 coincide with the date of a home visit?

A16. M0090, date assessment completed, records the date the assessment is completed. The start of care (SOC), resumption of care (ROC), follow-up, and discharge assessments (reason for assessments [RFA] 1, 3, 4, 5, and 9 for M0100) must be completed through an in-person contact with the patient; therefore these assessments will most often coincide with a home visit. The transfer or death at home assessments (RFAs 6, 7, or 8 for M0100) will report in M0090 the date the agency completes the assessment after learning of the event.
In the situation where the clinician needs to follow up, off site, with the patient's family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date. [Q&A EDITED 08/07]

Q17. M0090. If an HHA's policy requires personnel knowledgeable of ICD-9-CM coding to complete the diagnosis after the clinician has submitted the assessment, should M0090 be the date that the clinician completed gathering the assessment information or the date the ICD-9-CM code is assigned?

A17. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. CMS expects that each agency will develop their own policies and procedures and implement them throughout the agency in a manner that allows for correction or clarification of records to meet professional standards. It is appropriate for the clinician to enter the medical diagnosis on the comprehensive assessment. The HHA can assign a qualified coder to determine the correct numeric code based upon the written diagnosis provided by the assessing clinician. The date at M0090 (Date Assessment Completed) should reflect the actual date the assessment is completed by the qualified clinician. If agency policy allows the assessment to be performed over more than one visit, the date of the last visit (when the assessment is finished is the appropriate date to record. The M0090 date should not necessarily be delayed until coding staff verify the numeric codes. [Q&A added 06/05] [Q&A EDITED 08/07]

Q18. M0090. Should the date in M0090, reflect the date that a supervisor completed a review of the assessment?

A18. While a thorough review by a clinical supervisor may improve assessment completeness and data accuracy, the process for such review is an internal agency decision and is not required. The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected. [Q&A EDITED 08/07]

Q19. M0090. A provider has decided to complete discharge assessments for all patients when payers change because they believe that, by doing so, their reports will better indicate their patients' outcomes. Before making this policy shift they need answers to the following questions:

a. **Can the agency perform the RFA 09 and RFA 01 on the same visit?**
b. **If so, what is the discharge date for the RFA 09 at M0090?**
c. **If so, what is the admission date for RFA 01 at M0090?**

d. Will recording of the same date for both of these assessment result in errors when transmitted to the state agency?

A19. Under normal business practices, one home health visit should not include two types of assessments and be billed to two payer sources. The discharge date for the (RFA 09) Discharge from Agency should be the last date of service for the payer being terminated. The admission date for the new Start of Care (RFA 01) assessment should be the next scheduled visit, according to the plan of care. The agency may send a batch including both assessments to the state system. An edit is in place at the state system to sort for an assessment to close an open patient episode prior to opening a new episode. [Q&A added 06/05]

Q19.1. M0090. The RN conducted the SOC assessment on Monday. The RN waited to complete the assessment until she could confer with agency therapists after they had completed their therapy evaluations. This communication occurred on Tuesday and included a discussion of the plan of care and the therapists' input on the correct response for M0825. If the RN selects a response for M0825 based on the input from the therapists, does this violate the requirement that the assessment is to be completed by only one clinician? And what is the correct response for M0090, Date Assessment Completed?

A19.1: Tuesday would be the correct date for M0090. Tuesday was the date the assessing clinician gathered all the information needed to complete the assessment including M0825. In this case, the assessing clinician appeared to need to confer with internal agency staff to confirm the plan of care and the number of visits planned. M0825 is an item which is intended to be the agency's prediction of the number of therapy visits expected to be delivered in the upcoming episode, therefore, an agency practice may include discussion and collaboration among the interdisciplinary team to determine the M0825 response and this would not violate the requirement that the assessment be completed by one clinician. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #2]

Q20. M0100. Does 'transfer' mean 'transfer to another non-acute setting' or 'transfer to an inpatient facility?'

A20. Transfer means transfer to an inpatient facility, i.e., the patient is leaving the home care setting and being transferred to a hospital, rehabilitation facility, nursing home or inpatient hospice for 24 hours or more for reasons other than diagnostic testing. Note that the text of the item indicates that it means transfer to an inpatient facility. [Q&A EDITED 08/07]

Q21. M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it data entered? Is it transmitted? Is a discharge OASIS completed?

A21. Completion of a SOC Comprehensive Assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required

by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.
If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q22. M0100. Which reason for assessment (RFA) should be used when a patient is transferred to another agency?

A22. When a patient is transferred from one agency to another, the patient must be discharged using RFA 9 to enable the new agency to bill for the patient's care.

Q23. M0100. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care unit. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M0855?

A23. Yes, if the patient was admitted to an inpatient facility, the best response to M0100-Reason for Assessment (RFA) is Transfer to an Inpatient Facility. Depending on the agency policy, the choice may be RFA 6 transfer to an inpatient facility – patient not discharged or RFA 7 transfer to an inpatient facility – patient discharged. The agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M0855. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed, response 1 applies; or a nursing home bed, response 3 applies. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized. [Q&A added 06/05]

Q23.1. <u>M0100.</u> I understand that when calculating the days you have to complete the comprehensive assessment, the SOC is Day "0". At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day "0", e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Disch/trans/death date. Is M0906 Day "0"?

A23.1: Yes, when calculating the days you have to complete the comprehensive assessment, the SOC date is day "0". For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day "0".
Note that for the purposes of calculating a 60 day episode, the SOC day is day "1". [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #3]

Q23.2. M0100. A patient is admitted to the hospital for knee replacement surgery. During the pre-surgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility?

A 23.2: No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #4]

Q23.3. M0100. What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN?

A23.3: When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency's knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #5]

Q23.4. M0100. The CoPs require that the comprehensive assessment be updated within 48 hours of the patient's return home from the hospital. The OASIS Assessment Reference Sheet states that the Resumption of Care assessment be completed within 2 calendar days of the ROC date (M0032), which is defined as the first visit following an inpatient stay. Does this mean that the ROC assessment (RFA 3) must be at least started within 48 hours of the patient's return home, but can take an additional 2 days after the ROC visit to complete?

A23.4: No. When the agency has knowledge of a hospital discharge, then a visit to conduct the ROC assessment should be scheduled and completed within 48 hours of the patient's return home. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #6]

Q23.5. M0100. I accidentally completed the RFA 4 – Recertification assessment early (on day 54) for my Medicare patient. I did not realize this until I was into the next certification period. Should I do a new assessment or can the early assessment be used to establish the new case mix assignment for the upcoming episode?

A23.5: Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should not discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from Haven or Haven-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #7]

Q23.6. M0100. For the purposes of determining if a hospital admission was for reasons "other than diagnostic tests" how is "diagnostic testing" defined? I understand plain x-rays, UGI, CT scans, etc. would be diagnostic tests. What about cardiac catheterization, an EGD, or colonoscopy? (A patient does receive some type of anesthesia for these). Does the fact that the patient gets any anesthesia make it surgical verses diagnostic?

A23.6: Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of coronary artery disease (CAD). However, a cardiac catheterization may also be used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. The fact that the procedure requires anesthesia does not determine whether or not the procedure is purely diagnostic or not. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #9]

Q23.7. M0100 & M0855. HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under "observation status"). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e. no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a hospitalization? How do you answer M0100 & M0855?

A23.7: In order to qualify for the Transfer to Inpatient Facility OASIS assessment time point, the patient must meet 3 criteria:
1) Be admitted to the inpatient facility (not the ER, not an observation bed in the ER)
2) Reside as an inpatient for 24 hours or longer (does not include time spent in the ER)
3) Be admitted for reasons other than diagnostic testing only

In your scenario, you are describing a patient that is admitted to the inpatient facility, and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a hospitalization. The correct M0100 response would be either 6-Transfer to an Inpatient Facility, patient not discharged or 7-Transfer to an Inpatient Facility, patient discharged, depending on agency policy. M0855 would be answered with Response 1-Hospital as you state the patient was admitted to a hospital. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #10]

Q23.8. M0100/M0830. Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a "Patient Observation" or "PO" bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?

A23.8: For purposes of OASIS (M0830) Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M0830.

If from observation status the patient is eventually admitted to the hospital as an inpatient (assuming the transfer criteria are met), then this would trigger the Transfer OASIS assessment, and the agency would complete RFA 6 or RFA 7 data collection, depending on whether the agency chose to place the patient on hold or discharge from home care.

During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence. Outpatient therapy services provided during the period of observation would be included under consolidated billing and should be managed as such. The HHA should always inform the patient of consolidated billing at the time of admission to avoid non-payment of services to the outpatient facility.
If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified plan of care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria. The home health agency would bill for this patient as they would for any patient who was seen in an emergency room and returned home without admission to the inpatient facility following guidance in the Medicare Claims Processing manual.

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments

to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

Q23.9. M0100. An HHA has a patient who has returned home from a hospital stay and they have scheduled the nurse to go in to do the Resumption of Care visit within 48 hours. However, this patient receives both nursing and physical therapy and the PT cannot go in on the 2nd day (tomorrow) and would like to go in today. I have found the standard for an initial assessment visit must be done by a registered nurse unless they receive therapy only. Is this the same case for resumption? Is it inappropriate for the PT to go in the day before and resume PT services and the nurse then to go in the next day and do the ROC assessment update?

A23.9: The requirement for the RN to complete an initial assessment visit prior to therapy visits in multidisciplinary cases is limited to the SOC time point. At subsequent time points, including the ROC, either discipline (the RN or PT in the given scenario) could complete the ROC assessment. While the assessment must be completed within 48 hours of the patient's return home from the inpatient facility, there is no requirement that other services be delayed until the assessment is completed. Therefore, assuming compliance with your agency-specific policies and other regulatory requirements, there is no specific restriction preventing the PT from resuming services prior to the RN's completion of the ROC assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #12]

Q24. M0150. For M0150, Current Payment Sources for Home Care, what should be the response if the clinician knows that a patient has health insurance but that the Insurance typically won't pay until attempts have been made to collect from the liability insurance (e.g., for injuries due to an auto accident or a fall in a public place)?

A24. The purpose of this data item is to identify the current payer(s) that your agency will bill for services provided by your agency during this home care episode. Note that the text of M0150 asks for the "current payment sources" (emphasis added) and contains the instruction, "Mark all that Apply." For Medicare patients, the clinician should indicate at admission that the patient has Medicare coverage and any other coverage available that the agency will bill for services and mark all of the appropriate responses. The item is NOT restricted to the primary payer source. When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer.. For example, when a Medicare patient is involved in a car accident and someone's car insurance is paying for his/her home care, Medicare is the secondary payer and the response to M0150 should include either response 1 or 2 as appropriate for that patient. The only way an agency can bill Medicare as a

secondary payer is to consider that patient a Medicare patient from day 1, so that all Medicare-required documentation, data entry and data submission exist. Although the agency may "intend" that the private pay source will pay the entire cost of the patient's home care that usually cannot be verified at start of care and may not be determined until the care is completed. [Q&A EDITED 08/07]

Q25. M0150. Please clarify what Title V and Title XX programs are?

A25. Title V is a State-determined program that provides maternal, child health, and crippled children's services, which can include home health care. Title XX of the Social Security Act is a social service block grant available to States that provide homemaking, chore services, home management, or home health aide services. (Title III, also mentioned in Response 6 to M0150 is part of the Older Americans Act of 1965 that gives grants to State Agencies on Aging to provide certain services including homemaker, home-delivered meals, congregate nutrition, and personal care aide services at the State's discretion.)

Q26. [Q&A RECALLED 08/07]

Q27. M0150. A patient with traditional Medicare is referred for skilled services, and upon evaluation, is determined to *not* be homebound, and therefore *not* eligible for the home health benefit. The patient agrees to pay privately for the skilled services. Should M0150 include reporting of response 1 – Medicare (traditional fee-for-service)?

A27. The purpose of M0150 is to identify any and all payers to which any services provided during this home care episode are being billed. Although the patient described is a Medicare beneficiary, response 1 of M0150, Medicare (traditional fee-for-service), would not be marked, since the current situation described does not meet the home health benefit coverage criteria. In fact, since Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients, if the services will not be billed to Medicare or Medicaid, then no OASIS collection would be required for this patient; although, if desired, the agency may voluntarily collect it as part of the still-required comprehensive assessment. If at some point during the care, a change in patient condition results in the patient becoming homebound, and otherwise meeting the home health benefit coverage criteria, then a new SOC assessment would be required, on which response 1 – Medicare (traditional fee-for-service) would be indicated as a payer for the care. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #2]

Q28. M0150 The patient's payer source changes from Medicare to Medicaid or private pay. The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source?

A28. There is a discussion of payer source change in Chapter 8, Section E, of the *OASIS User's Manual.* Different States, different payers, and different agencies have varying responses to these payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer that question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-

assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source without a discharge. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to http://www.cms.hhs.gov/manuals/104_claims/clm104c10.pdf; scroll to page 94 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI. [Q&A EDITED 08/07]

Q29. M0150. Which pay sources should be noted when responding to M0150, current payment sources for home care?

A29. All current pay sources should be noted when responding to this item regardless of whether the pay source is primary or secondary. If Medicare and other pay source(s) are paying for care provided by a single agency, all the relevant pay sources should be noted. Note that the text of M0150 contains the instruction, "Mark all that apply."

Q29.1. M0150. Do I mark response 1, Medicare (traditional fee-for-service) if the patient's payer is VA?

A29.1: If the patient has both VA and Medicare and both are expected payers, then you need to mark Response 1, Medicare (traditional fee-for-service) and Response 7, Other government (e.g. CHAMPUS, VA, etc.). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7, Other government (e.g. CHAMPUS, VA, etc.) would be the correct response. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #8]

Q29.2. M0150. If a patient is receiving Meals-on-Wheels services, do you capture the payment for the service as a Response 10; Self Pay on M0150 Current Payment Sources for Home Care?

A29.2: No, food is not considered within the scope of M0150. Most patients pay for their food, whether they purchase it directly, a caregiver purchases and delivers it, or a service such as Meals-on-Wheels is utilized. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #9]

Q29.3. M0150. On M0150, since Response "10" – Self Pay should be marked for a patient who pays for their medications, should Response "1" Medicare (traditional fee-for-service) be marked for a patient whose medications are expected to be paid for in part by the Medicare drug benefit?

A29.3: No, M0150 is limited to identifying payers to which any services provided during this home care episode, and included on the home health plan of care will be billed by your home care agency. We are retracting a Q&A released in 06/05 which extended the

scope of M0150 to include reporting of "self pay" as a pay source for non-services (i.e. DME or medications) that are paid in part or full to a DME vendor or drug store for equipment or medications essential or integral to the home care episode. M0150 does not include payment for equipment, medications or supplies, and is limited to only services provided and billed for by your Medicare certified agency. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #10]

Q30. M0175. If the patient has outpatient surgery within the 14-day time frame described in M0175, should 1 or NA be marked?

A30. The correct response would be 'NA' for M0175 because the patient's status would have been an outpatient for this situation.

Q31. M0175. For M0175, what is the difference between response 3 (skilled nursing facility) and response 4 (other nursing home)?

A31. A skilled nursing facility (response 3) means a Medicare-certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit. Other nursing home (response 4) includes intermediate care facilities for persons with mental retardation (ICF/MR) and nursing facilities (NF). [Q&A EDITED 08/07]

Q32. M0175. M0175 refers to the inpatient facility from which the patient was discharged within the last 14 days. Please define 14 days.

A32. "During the past 14 days" refers to the two-week period immediately preceding the start of care/resumption of care (SOC/ROC) date or the first day of the new certification period at follow-up. The easiest way to determine this is to refer to a calendar. For example, if the SOC/ROC is Wednesday, August 20, look at a calendar to refer to the same day of the week two weeks ago, which in this case is August 6. For follow-up assessments, count fourteen days before the first day of the new certification period. [Q&A edited 06/05] [Q&A EDITED 08/07]

Q32.1. M0175. When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M0175 on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding the first day of the new certification period?

A32.1: When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M0175 should reflect inpatient facility discharges that have occurred during the two-week period immediately proceeding the first day of the new certification period. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #11]

Q33. M0180. In OASIS field M0180, if there is no date, do you just fill in zeros?

A33. As noted in the skip instructions for item M0175, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M0175 has a response of NA), M0180 and M0190 should be skipped. If the patient was discharged from an inpatient facility during the past 14 days, but the date is unknown, you should mark UK at M0180 and leave the date blank.

Q34. M0190. How would additional inpatient facility diagnoses and ICD-9-CM codes be entered into M0190 since the field only allows for two sets of codes? When we include this item in our clinical forms, can we add more lines?

A34. M0190 requests the two most relevant diagnoses that were actively treated during the inpatient facility stay, not all diagnoses that the patient may have. Agencies should carefully consider whether additional information is needed and, if so, how only the most relevant information is listed in "a" and "b" of M0190. OASIS items must be reproduced in the agency clinical forms exactly as they are written. If the agency desires additional information, the most appropriate course of action may be to insert an additional clinical record item immediately following M0190. [Q&A EDITED 08/07]

Q35. M0190. It takes days (sometimes even a week) to get the discharge form from the hospital. How can we complete this item in a timely manner?

A35. Information regarding the condition(s) treated during the inpatient facility stay has great relevance for the SOC/ROC assessment and for the plan of care. The agency may instruct intake personnel to gather the information at the time of referral. Alternatively, the assessing clinician may contact the hospital discharge planner or the referring physician to obtain the information.

Q36. M0190. Can anyone other than the assessing clinician enter the ICD codes?

A36. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the severity indices. The clinician should write-in the medical diagnosis requested in M0190, M0210, M0230/M0240, and M0245, if applicable. A coding specialist in the agency may enter the actual numeric ICD-9 codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency. [Q&A EDITED 08/07]

Q37. M0190/M0210. What is the difference between M0190 and M0210?

A37. M0190 and M0210 refer to two separate situations. M0190 relates to a patient who has been discharged from an inpatient facility within the past 14 days and reports the diagnoses for conditions that were treated during the inpatient facility stay. M0210 relates to a change in the patient's medical or treatment regimen during the same past 14 days. The diagnoses in the two items may be the same, but there is no requirement that they be identical. For a patient who was not discharged from an inpatient facility during the past 14 days, M0190 would be skipped.

Q38. M0200/M0210. Please clarify M0200 - Medical or Treatment Regimen Change within past 14 days and M0210 - Medical Diagnoses (for conditions requiring the change).

A38. For M0200, identify whether any change has occurred in the patient's medical or treatment regimen in the past 14 days. Is there a new diagnosis or an exacerbation of an old diagnosis that necessitates a change in the treatment regimen? For example, has there been a medication dosage change? Are therapy services newly ordered as a treatment regimen change? Has a regimen change occurred in response to a change in patient health status? M0210 then asks what medical diagnosis has necessitated this change in regimen? Was the diuretic increased due to an exacerbation of congestive heart failure? Was the patient started on insulin due to a new diagnosis of diabetes?

Q39. M0200. Must the "new or changed diagnosis" have occurred in the last 14 days?

A39. M0200 asks about a change in the patient's medical or treatment regimen, not about a "new or changed diagnosis." It is possible that the treatment regimen change occurred because of a new or changed diagnosis, but the item only asks about the medical or treatment regimen change occurring within the past 14 days. The change may have occurred because of an exacerbation or improvement of an existing diagnosis. [Q&A EDITED 08/07]

Q40. M0200. If the patient had a physician appointment in the past 14 days, or has a referral for home care services, does that qualify as a medical/treatment regimen change?

A40. A physician appointment by itself or a referral for home health services does not qualify as a medical or treatment regimen change.

Q41. M0200. If the treatment regimen change occurred on the same day as the visit, does this qualify as within the past 14 days?

A41. A treatment regimen change occurring on the same day as the assessment visit does qualify as occurring within the past 14 days.

Q42. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat4b, Q #40.]

Q42.1. M0200. I was told that an exacerbation of a disease can be considered a change in medical or treatment regimen for M0200, Medical or Treatment Regimen Change Within Past 14 Days. Is this true?

A42.1: The exacerbation of a disease, in and of itself, would not be considered a change in medical or treatment regimen for M0200. The changes in medication, service, or treatment that might result from a new diagnosis or the exacerbation of a disease would warrant in a "Yes" response on M0200. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #12]

Q42.2. M0200. If physical therapy (or any other discipline included under the home health plan of care) was ordered at Start of Care (SOC) and discontinued during the episode, does this qualify as a service change for M0200 at the Resumption of Care (ROC) or DC OASIS data collection time points? I understand that the referral and admission to home care does not qualify as a med/tx/service change for M0200.

A42.2: Physical therapy (or any other discipline) ordered at SOC and then discontinued during the episode, qualifies as a service change for M0200 at the ROC or DC OASIS data collection time points. You are correct that referral and admission to home care does not "count" as a medical or treatment regimen change. This means that all home care services or treatments ordered at SOC/ROC would not "count" for M0200, but would thereafter, if there was a change.

While a treatment change occurring on the same day as the assessment visit usually qualifies as occurring within the past 14 days, the discontinuation of home care services at DC, do NOT count as a "Yes" for M0200 (If it did, all episodes would include a "Yes" on M0200 at DC.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #13]

Q43. M0210. For the medical diagnosis in the changed medication section at OASIS item M0210, does this need to be the current diagnosis we are seeing the patient for, or a diagnosis that is specific for the medication?

A43. Item M0210 identifies the diagnosis(es) causing a change to the patient's treatment regimen, health care services, or medication within the past 14 days. The ICD-9 code can be a new diagnosis or an exacerbation of an existing condition that is specific to the changed medical or treatment regimen. Also note that this item is not restricted to medications, but refers to any change in medical or treatment regimen. [Q&A EDITED 08/07]

Q44. M0230/M0240/M0245. It is difficult to understand when an ICD-9-CM code must be entered at M0245. Where can we find help?

A44. For Clarification of OASIS items M0230, M0240, and M0245 please refer to the *OASIS User's Manual*, Attachment D to Chapter 8, at: http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. [Q&A EDITED 08/07]

Q44.1. M0230/M0240. During a supervisor's audit of a SOC assessment, the auditor finds a manifestation code listed as primary without the required etiology code reported. Can this be considered a technical coding "error", and can the agency follow their correction policy allowing the agency's coding expert to correct the non-adherence to multiple coding requirements mandated by the ICD-9-CM coding guidelines, without conferring with the assessing clinician?

A44.1: The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M0230, and ICD-9-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a diagnosis is being added. If any diagnosis is being added, in this case for manifestation coding requirements, the assessing clinician must be contacted and agree.

If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a "technical" error and the coding specialist may not automatically make the correction without consulting with the assessing clinician.

If after discussion of the manifestation coding situation between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor and that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC using current ICD-9-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #14]

Q44.2. M0230/M0240. Is it true that you can never change M0230 or M0240 from the original POC (cert) until the next certification?

A44.2: Guidance in Chapter 8 of the OASIS User's manual, pg. 8.42 and 8.145, states the primary diagnosis is the chief reason the agency is providing home care, the condition most related to the plan of care. Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." "In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself." M0230, Primary Diagnosis and M0240, Other Diagnoses are reported at Start of Care, Resumption of Care and Follow-up/Recertification. At each time point, after completing a comprehensive assessment of the patient and receiving input from the physician, the clinician will report the patient's current primary and secondary diagnoses. Diagnoses may change following an inpatient facility stay - the Resumption of Care and following a major change in the patient's health status - the Other Follow up. The chief reason an agency is caring for a patient may change. The focus of the care may change. At each required time point the clinician will assess and report what is true at the time of the assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #13]

Q45. M0250. Does M0250 refer to the therapies the patient is receiving when the staff member walks in to do the OASIS assessment? What if the patient is known to need enteral feedings and is scheduled for setup post-OASIS assessment? Please clarify.

A45. M0250 refers to therapies the patient is receiving during the day of the assessment or which the patient is ordered to receive as a result of the assessment visit. For example, if the assessment reveals the existence of dehydration, and the clinician's communication results in an order for IV therapy, response 1 would be marked. [Q&A EDITED 08/07]

Q46. M0250. Does a central line (OR subcutaneous infusion OR epidural infusion OR intrathecal infusion OR an insulin pump OR home dialysis, including peritoneal dialysis) "count" in responding to M0250?

A46. Only one question must be answered to determine whether these examples "count" as IV or infusion therapy -- is the patient receiving such therapy at home? If the patient were receiving such therapy at home, then response 1 for M0250 would be appropriate. If the infusion therapy is administered in the physician's office or outpatient center or dialysis center, and no infusion or flush is occurring in the home, response 4 would be marked. [Q&A edited 06/05] [Q&A EDITED 08/07]

Q47. M0250. Does an IM or SQ injection given over a 10-minute period "count" as an infusion?

A47. No, this injection does not "count" as infusion therapy.

Q48. M0250. If the patient refuses tube feedings, does this "count" as enteral nutrition?

A48. If the patient's refusal has resulted in the patient not receiving enteral nutrition on the day of the assessment, response 3 would not be appropriate at the time of the assessment. The refusal of the tube feedings would be noted in the clinical record. Flushing the feeding tube does not provide nutrition. [Q&A EDITED 08/07]

Q49. M0250. If the caregiver provides the enteral nutrition independently, should response 3 be marked, or does the HHA need to provide the care?

A49. M0250 simply asks about therapies the patient is receiving at home. Since this patient is receiving enteral nutrition at home, response 3 should be marked.

Q50. M0250. Do therapies provided in the home have to be documented in the clinical record?

A50. It seems clear that any of the therapies identified in M0250 (IV/infusion therapy, parenteral nutrition, enteral nutrition) would be acknowledged in the comprehensive assessment and be noted in the plan of care. Even if the family or caregiver manages the therapies completely independently, the clinician is likely to evaluate the patient's nutritional or hydration status, signs of infection, etc. It is difficult to conceive of a situation where the answer to this question would be "no."

Q51. M0250. Does M0250 relate to other OASIS items?

A51. Note the subsequent items of M0810 (Patient Management of Equipment) and M0820 (Caregiver Management of Equipment), which address IV/infusion therapy and enteral/parenteral equipment or supplies.

Q52. M0250. If the discharge visit includes discontinuing IV or infusion therapy, should the OASIS item (M0250) reflect the presence of these services on the discharge assessment?

A52. Yes, if the IV is being discontinued the day of the assessment visit, then those respective services can be marked as "present" at the assessment. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #3]

Q53. M0250. A patient has an order on admission for an IV infusion to be given prn, if specific parameters are present. None of the parameters exist at SOC, and no IV line is inserted. What is the appropriate response to M0250?

A53. If the patient will receive an IV infusion as a result of the SOC assessment (i.e., the predetermined parameters are met), then response 1 is appropriate. If the parameters are not met at the SOC assessment, then response 1 does NOT apply. [Q&A added 06/05] [Q&A EDITED 08/07]

Q53.1. M0250. When a patient has a G-tube (NG-tube, J-tube, and PEG-tube) and it is only utilized for medication administration, do you mark Response 3, Enteral nutrition for M0250, Therapies?

A53.1: No, M0250 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #15]

Q53.2. M0250. When a patient has a feeding tube and it is only utilized for the administration of water for hydration (continuous or intermittent), do you mark Response 3, Enteral nutrition for M0250, Therapies?

A53.2: No, M0250 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #16]

Q53.3. M0250. I understand that if the patient is receiving infusion therapy in the home and the family or caregiver manages it completely that we should report the infusion therapy on M0250. Is this also true when the patient is receiving infusion therapy in the home from another provider?

A53.3: Only one question must be answered to determine whether the infusion "counts" as IV or infusion therapy – "Is the patient receiving such therapy at home?" regardless of who is managing it. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #17]

Q53.4. M0250. A patient has a Hickman catheter and is receiving TPN over 12 hours. At the beginning of the infusion, the line is flushed with saline and at the end of the infusion, it is flushed with saline and Heparin. For M0250, do you mark both 1 and 2?

A53.4: When the patient is receiving intermittent parenteral therapy at home and requires a pre- and post-infusion flush, it is not appropriate to mark Response 1, Intravenous or infusion therapy (excludes TPN), in addition to Response 2, Parenteral nutrition (TPN or lipids). The flushing of the line for intermittent parenteral therapy is considered a component of the parenteral therapy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #18]

Q53.5. M0250. If a patient's appetite is poor and he/she has a g-tube and the physician orders Ensure prn through the g-tube? Does this count as enteral nutrition for this item?"

A53.5: If a PRN order exists and the patient meets the parameters for administration of the feeding based on the findings from the comprehensive assessment, or has met such parameters and/or received enteral nutrition at home in the past 24 hours, the assessing clinician would mark Response 3. The clinician could not mark response 3 automatically when a PRN order exists at SOC because it is unknown if the patient will ever receive the enteral nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #14]

Q53.6. M0250. We have been admitting patients status post lumpectomy for breast cancer. After the surgery, they are discharged with an eclipse (bulb) that

has Marcaine or Lidocaine that infuses pain medication into the wound bed. After 48 hours the bulb can be removed. If the patient still has this bulb on at start of care, should Response 1 be marked for M0250?

A53.6: When a patient is receiving an infusion at home, M0250 should be marked with Response 1-Intravenous or infusion therapy. If the patient you describe is receiving a local anesthetic via an infusion device while in the home, M0250 would be marked "1" at SOC. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #5]

Q54. M0260. Does Overall Prognosis, M0260, refer to the prognosis of the primary diagnosis or the overall prognosis? For instance, if a patient had a primary diagnosis of fractured hip from which he would recover and a secondary diagnosis of cancer for which gradual deterioration was expected, would the prognosis be "good" because it refers only to the hip fracture?

A54. The focus of M0260 is the overall prognosis for recovery from this episode of illness (for which the home care is being provided). In the example, if the patient's recovery from the hip fracture is complicated by metastasis of the cancer to the bone, then the patient's condition might be noted as response 0-Poor, according to the clinician's assessment. Patient prognosis is also required for the Plan of Treatment.

Q55. M0280. Life Expectancy is assessed at the Start of Care, Resumption of Care, and at Discharge. We don't have the opportunity to change this response if there is a change in the patient and there is no intervening inpatient stay. What should we do?

A55. The reduced burden OASIS did remove the opportunity to update this item with another assessment (RFA4/5). Please document any changes in your patient in the patient's clinical record when there is a change in his/her status.

Q56. M0340. How should we respond to M0340 for patients living in an Assisted Living Facility (ALF)?

A56. Rules for licensing Assisted Living Facilities vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. This item simply asks who the patient lives with, not about the type of assistance that the patient receives. For example: a patient living in his/her own room would be response #1, Lives alone, while a patient sharing a room or studio apartment with someone would be response #2 (With spouse or significant other) or #4 (With a friend).

Q57. M0340. My patient lives alone Monday through Friday but has hired help to stay with her on the weekend; how should I respond to this item?

A57. Weekend help would be considered "intermittent' help according to the item-by-item tips found in Chapter 8 of the *OASIS User's Manual*. Therefore, the correct response in this situation would be "1 - Lives alone."

Q57.1. M0340. What if paid help lives with the patient Monday through Friday, would we still score, in this section, 1-lives alone? My understanding is that this section is not asking about what kind of help the patient receives.

A57.1: You are describing paid help that lives with the patient intermittently, Monday through Friday. Intermittent (e.g., a few hours each day, one or two days a week, etc.) paid help is not classified as help the patient "lives with." The correct response for M0340, in this case, would be 1-Lives alone.

M0340 is asking with whom the patient is living with at the time of the assessment, even if the arrangement is temporary. Subsequent items will capture information about the primary caregiver and the type and quantity of assistance s/he provides. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #15]

Q57.2. M0340 & M0350. What are the correct responses for M0340 and M0350 in the situation where family members that live outside the home are staying around the clock with a patient (caregivers are taking turns with each other)? If the patient has 24 hour supervision from people outside the home, is the patient living alone?

A57.2: Chapter 8, Page 8.51 of the OASIS Implementation Manual (www.cms.hhs.gov/OASIS/05_UserManual.asp) instructs that M0340 should identify whomever the patient is living with at the time of the assessment, even if the arrangement is temporary. It does not simply ask if the patient has 24 hour companionship or supervision, but who the patient lives with.

In situations where multiple caregivers/family members stay with the patient for a number of hours each day, if each of the caregivers comes and goes to their own residences outside of the patient's home, then they do not live with the patient, even if the cumulative "coverage" equates to 24 hour supervision/companionship. The patient is living alone and M0340 should be reported as response 1 - Lives alone. These caregivers should be considered when reporting assisting persons for M0350 (unless they are home care agency staff), and response 1 - relatives, friends or neighbors living outside the home, should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #16]

Q58. M0350. How should we respond to M0350 for patients living in an Assisted Living Facility (ALF)?

A58. Rules for licensing Assisted Living Facilities (ALFs) vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. Most patients in an ALF are receiving paid help, at least (#3 under M0350), although they may also be receiving help from others listed. Refer to the explanation for this item in the *OASIS User's Manual*, Chapter 8, available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. [Q&A EDITED 08/07]

Q59. M0350. Is Meals-on-Wheels considered assistance for M0350?

A59. M0350 is asking the clinician to identify assisting person(s) other than home care agency staff. Response 3, paid help, includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family or a specific program. Meals-on-Wheels is a community-based service that assists the homebound by delivering meals and would be included in responding to M0350. [Q&A added 06/05; Previously CMS OCCB 03/05 Q #3]

Q60. M0360. How should we respond to OASIS item M0360 for patients living in an Assisted Living Facility (ALF)?

A60. Rules for licensing ALFs vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. The clinician making the assessment will need to determine who the primary caregiver is, and mark the appropriate response under M0360 and continue through the remaining items pertaining to the assistance provided by the primary caregiver. Refer to the explanations for these items in the *OASIS User's Manual*, Chapter 8, available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp [Q&A EDITED 08/07].

Q61. M0360. How should the item be answered if one person takes the lead responsibility, but another individual helps out most frequently?

A61. The clinician should assess further to determine whether one of these individuals should be designated as the primary caregiver or whether response 0 (No one person) is the most appropriate description of the situation.

Q62. [Q&A DELETED 08/07; Duplicative of Chapter 8, OASIS User's Manual]

Q63. M0390. How is vision evaluated for the patient who is too disoriented and cognitively impaired for the clinician to assess?

A63. A caregiver may be able to assist by demonstrating the patient's response to an object that is familiar to him/her. Alternatively, this could be a situation where the patient is not able to respond, thus is nonresponsive (response 2).

Q64: M0390. Does information on vision documented in OASIS have to be backed up with documentation elsewhere in the patient's record?

A64. A patient who has partially or severely impaired vision (responses 1 or 2) is likely to require adaptations to the care plan as a result of these limitations. Therefore, it is likely that the vision impairments would be included in additional assessment data or as rationale for care plan interventions.

Q64.1. M0390. If a patient has a physical deficit, such as a neck injury, limiting his range of motion, which affects his field of vision and ability to see obstacles in his path, how is M0390, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected.

A64.1: When selecting the correct response for M0390, Vision, the clinician is assessing the patient's functional vision, not conducting a formal vision screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical deficits or impairments that limit the patient's ability to use their existing vision in a functional way would be considered. If a patient sustained an injury that limits neck movement, the patient may not be able to see obstacles in their path. A patient who has sustained a facial injury may have orbital swelling that makes it impossible for them to see and they must locate objects by hearing or touching them. Conversely, it is possible for a patient

to be blind in one eye (technically not "normal vision"), but still be appropriately scored a "0" on M0390 if with the patient's existing vision, they are able to see adequately in most situations and can see medication labels or newsprint. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #6]

Q65: M0400. Our agency would like clarification concerning M0400 - Hearing and Ability to Understand Spoken language in patient's own language. If a patient speaks Spanish and there is an interpreter, it is difficult to ascertain the level of complexity of interpreted instructions. How are we to answer this?

A65. You will need to ask the interpreter to help you determine at what level the patient is responding. Responses to 'No observable impairment' (0) and 'Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive' (4) should be relatively simple to determine. To determine the difference between levels 1, 2 or 3, you can interact with the interpreter to determine with what difficulty the patient is responding. Inasmuch as the assessment includes assistance from an interpreter, your clinical documentation of the visit should indicate the presence of an interpreter who assists with communication between clinician and patient.

Q66. M0400. Is it correct that both auditory and receptive language functions are included in responding to this item? Therefore a deaf patient who processes spoken language effectively using lip reading strategies is scored at response level 4 (Unable to hear and understand) because the item measures the combination of BOTH hearing and comprehension?

A66. Yes, M0400 does include assessment of both hearing AND understanding spoken language. A patient unable to hear (even with the use of hearing aids if the patient usually uses them) would be scored at response level 4. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #4]

Q66.1. M0400. My patient's primary language is German, but he does speak English well enough for us to generally communicate without the use of an interpreter. Often I need to repeat my request, or reword my statements, but he eventually adequately understands what I'm asking or saying. When scoring M0400 Hearing and Comprehension of Spoken Language, I marked response "2" based on my assessment, but I wonder if the patient's hearing/comprehension would be better (i.e., a Response "0" or "1") if he were being spoken to in German, his primary language. Do I have to assess the patient with an interpreter in order to score M0400 in the patient's primary language, even if I feel communication is generally adequate to allow evaluation of the patient's healthcare needs and provision of care outlined in the Plan of Care?

A66.1: M0400 is an evaluation of the patient's ability to hear and understand verbal (spoken) language in the patient's primary language. If a patient is able to communicate in more than one language, then this item can be evaluated in any language in which the patient is fluent. If however, as you suggest, your patient's ability to hear and understand is likely not as functional in a secondary language, you should make efforts necessary to access an interpreter to determine the patient's ability to hear and comprehend in the patient's primary language. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #19]

Q67. M0410. How do I respond to this item if the patient uses sign language? What about a patient who communicates by writing?

A67. This item addresses the patient's ability to speak and orally (verbally) express himself/herself, not general communication ability. If the patient depends entirely on sign language or writing and is unable to speak, response 5 applies. The clinician would want to document the patient's general communication ability in another location in the clinical record, as this is important for care provision.

Q68. M0410. Can this item be answered if a patient is trained in esophageal speaking or uses an electrolarynx?

A68. Augmented speech (through the use of esophageal speech or an electrolarynx) is considered oral/verbal expression of language.

Q69. M0420. How can you assess if pain is interfering with activity or movement in a nonverbal patient? A nonresponsive patient?

A69. Nonverbal or nonresponsive patients experience pain, and careful observation establishes its presence and affect on activity or movement. The clinician should observe facial expression (frowning, gritting teeth), note changes in pulse rate, respiratory rate, perspiration, pallor, pupil size, or irritability, or signs that activity is being affected by pain (e.g., limping, guarding). [Q&A EDITED 08/07]

Q70. M0420. For pain to "interfere," does it have to prevent that activity from occurring? Or just alter or affect the frequency or method with which the patient carries out the activity?

A70. For pain to interfere with activity, it does not have to totally prevent the activity. Examples of how pain can interfere with activity without preventing it include: if pain causes the activity to take longer to complete, results in the activity being performed less often than otherwise desired by the patient, or requires the patient to have additional assistance. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #5]

Q71. M0420. If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity?

A71. If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management and should not, in and of itself, be considered as an "interference" to the patient's activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considers as "affected" or "interfered with" by pain, and the frequency of such interference should be assessed when responding to M0420. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #6]

Q72. M0420. Would a patient who restricts his/her activity (i.e., doesn't climb stairs, limits walking distances) in order to be pain-free thus be considered to have pain interfering with activity? And if so, would the clinician respond to

M0420 based on the frequency that the patient limits or restricts their activity in order to remain pain-free?

A72. Yes, a patient who restricts his/her activity to be pain-free does indeed have pain interfering with activity. Since M0420 reports the frequency that pain interferes with activity (not the presence of pain itself), then M0420 should be scored to reflect the frequency that the patient's activities are affected or limited by pain, even if the patient is pain free at present due to the activity restriction. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #7]

Q73. M0420. A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Is pain interfering with the patient's activity?

A73. M0420 identifies the frequency with which pain interferes with a patient's activities, taking into account any treatment prescribed. If a patient is pain-free as a result of the treatment, M0420 should be answered to reflect the frequency that the patient's activities are affected or limited by pain. In this scenario, the patient is described as being pain-free, but also is described as having medication side effects that interfere with activity. Medication side effects are not addressed in responding to M0420 and, given the information in the scenario; pain apparently is not interfering with the patient's activity. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #3]

Q74. M0430. Our agency would like clarification of the question concerning how M0430, Intractable pain, is assessed. In our agency, intractable pain is often interpreted as cancer pain. However, the term used in the question, 'not easily relieved' opens the door to very wide interpretation.

A74. In this data item, we are assessing the presence of intractable pain as defined in Chapter 8 of the *OASIS User's Manual*. Intractable pain refers not only to cancer pain but also to pain of other etiologies that occurs at least daily, is not easily relieved, which may affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. This type of pain likely interferes with the patient's activities and needs to be considered when developing the plan of care. [Q&A EDITED 08/07]

Q75. M0430. A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Based on the information provided, would this patient be considered to have intractable pain?

A75. Intractable pain refers to pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. The clinician making the assessment will determine if the patient's pain meets the components of the definition of intractable pain. If the pain is well controlled by round-the-clock pharmacologic interventions, then the pain may not occur daily, and therefore would not be considered intractable. The assessing clinician, with input from the patient, will determine if the pain is easily relieved and will identify the effects of the pain on the patient's activities and life.

Note that M0420 and M0430 are separate items and should be assessed and considered separately. There is not an "if response ... on M0420, then response ... on M0430" algorithm that is appropriate to follow in responding to these items. [Q&A added 06/05] [Q&A EDITED 08/07]

Q76. [Q&A DELETED 08/07; Duplicative of Chapter 8, OASIS User's Manual]

Q77. [Q&A DELETED 08/07; Outdated. Terminology deleted from current version of Chapter 8]

Q77.1. M0430. My patient has post-op pain which initially was well managed with pain medications. For the past few weeks the patient has been refusing to take her pain medications as prescribed due to fear of addiction. This has caused her to have pain that occurs at least daily and impacts her ability to sleep, get around her home, and carry out her home exercise program. The patient is being discharged to outpatient services. On my discharge assessment, I marked that the patient did NOT have intractable pain, because she could have "easily" relieved her pain if she took her pain medications as prescribed. Is this an appropriate application of the current guidance?

A77.1: The assessing clinician, with input from the patient, will determine if the pain is easily relieved. In your example, it appears that you believe the patient's pain *could* easily be relieved, but in reality it is not relieved due to a fear of addiction. M0430 should be a reflection of the patient's current pain and its current impact on the patient's life, given the current parameters (e.g., pain level and characteristics, pharmacological and non-pharmacological treatments used). If the patient is not currently using adequate pain medication or non-drug pain management measures, even if they have been prescribed, and are present in the home, M0430 should still be a reflection of the patient's current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #20]

Q77.2. M0430. My patient reports he can not afford to buy his pain medications, and does have pain that occurs at least daily and interferes with quality of life issues. Can I say that the pain is not easily relieved because the patient does not have a means to relieve it?

A77.2: Knowledge that the patient is not currently taking medications as prescribed due to financial concerns is certainly an important finding that should be documented in the drug regimen review portion of the comprehensive assessment and addressed in the plan of care. If the patient is not currently using adequate pain medication, for any reason, including inability to afford medications prescribed, M0430 should still be a reflection of the patient's current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #21]

Q78. M0440. For M0440, Integumentary Status, please clarify CMS's interpretation of a skin lesion.

A78. 'Lesion' is a broad term used to describe an area of pathologically altered tissue. Wounds, sores, ulcers, rashes, crusts, etc. are all considered lesions. So are bruises or

scars. In responding to the item, the only 'lesions' that should be disregarded are those that end in 'ostomy' (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites (central line sites are considered to be surgical wounds). For additional types of skin lesions, please consult a physical assessment text.

Q79. M0440. How many different types of skin lesions are there anyway?

A79. Many different types of skin lesions exist. These may be classified as primary lesions (arising from previously normal skin), such as vesicles, pustules, wheals, or as secondary lesions (resulting from changes in primary lesions), such as crusts, ulcers, or scars. Other classifications describe lesions as changes in color or texture (e.g., maceration, scale, lichenification), changes in shape of the skin surface (e.g., cyst, nodule, edema), breaks in skin surfaces (e.g., abrasion, excoriation, fissure, incision), or vascular lesions (e.g., petechiae, ecchymosis).

Q80. M0440. Is a pacemaker considered a skin lesion?

A80. A pacemaker itself is an implanted device but is not an implanted infusion or venous access device. The (current) surgical wound or (healed) scar created when the pacemaker was implanted is considered a skin lesion.

Q81. M0440. How should M0440 be answered if the wound is not observable?

A81. The definition of the term "nonobservable" varies depending on the specific OASIS item being assessed. If you know from referral information, communication with the physician, etc. that a wound exists under a nonremoveable dressing, then the wound is considered to be present for M0440, and the item would be answered "Yes." [Q&A EDITED 08/07]

Q82. M0440. Is a new suprapubic catheter, new PEG site, or a new colostomy considered a wound or lesion?

A82. A new suprapubic catheter site (cystostomy), new PEG site (gastrostomy) and a new colostomy have one thing in common -- they all end in "-ostomy." All ostomies, whether new or long-standing are excluded from consideration in responding to M0440. Therefore, none of these would be considered as a wound or lesion.

Q83. M0440. How should M0440 be answered if the wound/lesion is a burn?

A83. M0440 should be answered, "yes," since a lesion is present. Additional documentation that describes the burn should be included in the clinical record, but burns are not addressed in the OASIS items. The appropriate ICD-9-CM code for the burn should be entered in M0230 Primary Diagnosis or M0240 as appropriate for accurate documentation. [Q&A EDITED 08/07]

Q84. M0440. Do all scars qualify as skin lesions?

A84. Yes, a scar meets the definition of an "area of pathologically altered tissue." [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #8]

Q85. M0440. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a skin lesion at M0440?

A85. For M0440 you would answer YES for a lesion and continue answering the questions until you come to M0482 - Does this patient have a surgical wound? Respond Yes - #1. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion.

Q86. M0440. Are implanted infusion devices or venous access devices considered skin lesions at M0440?

A86. Yes, the surgical sites where such devices were implanted would be considered lesions at M0440 and would be included in the total number of surgical wounds (M0484). It does not matter whether the device is accessed at a particular frequency or not. [Q&A EDITED 08/07]

Q87. M0440. How do we document other wounds that are not surgical, pressure ulcers, or stasis ulcers at M0440?

A87. Remember that OASIS items are only PART of a comprehensive assessment and include only those items that have proven useful for outcome measurement and risk factor adjustment. During the early stages of the research on which OASIS items are based, the status of many such lesions were tested for their utility as outcome measures. Only the types of wounds that 'worked' for outcome measurement or risk factor adjustment have been carried forward in OASIS, though other types of wounds are extremely important to document in the clinical record. The presence of ANY wound or lesion (other than ostomies and peripheral IV sites) should be noted by a 'yes' response to M0440. [Q&A EDITED 08/07]

Q87.1. M0440 – M0488. Do CMS OASIS instructions supersede a clinical wound nurse training program?

A87.1: CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Ulcer Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards. While CMS provides specific instructions on how OASIS data should be classified and reported, OASIS scoring guidelines are not intended to direct or limit appropriate clinical care planning by the nurse or therapist. For instance, even though for OASIS data collection purposes a gastrostomy is excluded as a skin lesion or open wound, such data collection exclusion does not suggest that the clinician should not assess, document and include in the care plan findings and interventions related to the gastrostomy. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #22]

Q88. M0440/M0482. Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440 and a surgical wound for M0482?

A88. No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #4]

Q88.1. M0440/M0482. Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?

A88.1: The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #22]

Q89. M0440/M0445/M0468. Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at M0440 and M0445?

A89. The clinician will have to speak with the physician who must make the determination as to whether a specific lesion is a diabetic ulcer, a pressure ulcer, stasis ulcer, or other lesion. There are some very unique coding issues to consider for ulcers in diabetic patients (vs. ulcers in non-diabetic patients), and the physician should be aware of these in his/her contact with the patient. In responding to the OASIS items, an ulcer diagnosed by the physician as a diabetic ulcer would be considered a lesion (respond "yes" to M0440), but it would not be considered a pressure ulcer or a stasis ulcer.

Q89.1. M0445. If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?

A89.1: No, covering a pressure ulcer with a skin graft does not change it to a surgical wound. It remains a pressure ulcer. Applying a skin graft to a burn does not become a surgical wound. The burn remains a skin lesion, with details captured in the comprehensive assessment. In either case, a donor site, until healed, would be considered a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #23]

Q90: M0450. When staging pressure ulcers, are we to keep the stage the same throughout all assessment time points even though the ulcer is healing? According to AHCPR guidelines for pressure ulcers we should keep the staging the same (once a stage 4 it stays a stage 4 but we document if healing is occurring). Are we to show that a Stage 4 went to a Stage 3 if this occurred at two different time points?

A90: Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is stage 4 at Start of Care and is granulating at the follow-up visit, the pressure ulcer remains a stage 4 ulcer. Your clinical documentation (and possibly the M0464 Status of Most Problematic (Observable) Pressure Ulcer score on a subsequent assessment) will reflect the healing process. The NPUAP web site

(http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc. [Q&A EDITED 08/07]

Q90.1. M0450, M0460. I have reviewed the new 2/07 NPUAP pressure ulcer staging document and it states that a pressure ulcer with slough or eschar can be staged if the necrotic tissue does not obscure the wound bed preventing visualization of tissue loss. There is a CMS OCCB Q&A dated 7/06 that states you cannot stage a pressure ulcer when any amount of eschar or slough is present, even when the bone is visible. Can I stage a pressure ulcer when eschar or slough is present as long as the wound bed is visible?

A90.1: Yes, you can stage a pressure ulcer when some eschar or slough is present as long as the wound bed is visible and you can see the extent of tissue involved. In response to the latest National Pressure Ulcer Advisory Panel (NPUAP) guidance, we are retracting the CMS OCCB Q&A #24 dated 7/06 that states "any pressure ulcer with any amount of eschar or slough present, even an ulcer with bone visible, would be considered non-observable and therefore could not be staged."
In the latest NPUAP staging document, the Stage III pressure ulcer definition states "Slough may be present but does not obscure the depth of tissue loss." The Stage IV pressure ulcer definition states "Slough or eschar may be present on some parts of the wound bed." An Unstageable pressure ulcer has "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined."

The new NPUAP staging document is also consistent with the latest (7/06) WOCN guidance on OASIS skin and wound status M0 items in which the Stage III pressure ulcer definition includes the statement that: "Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia." and that a Stage IV pressure ulcer includes: "Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule)." These definitions state that Stage III and IV pressure ulcers can have necrotic tissue present and therefore are NOT unstageable. The WOCN does go on to explain that a non-observable pressure ulcer is a "Wound unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and /or slough cannot be staged, and should be documented as non-observable." which again is supported by the NPUAP 2/07 document.

These new definitions are consistent with the Chapter 8 guidance for M0450, Current Number of Pressure Ulcers at Each Stage that states "A pressure ulcer cover by eschar or a nonremoveable cast or dressing cannot be staged...", "The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed." and "Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training."

The 2/07 NPUAP's Pressure Ulcer Staging document can be accessed at www.npuap.org. The WOCN's Guidance on OASIS Skin and Wound Status M0 Items

document can be accessed at www.wocn.org. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #7]

Q91. M0450-M0464. At M0450-M0464, should we document a pressure ulcer when its stage or status worsens?

A91. Absolutely. If a pressure ulcer worsens in stage (or if its status worsens), this information should be noted in M0450 through M0464.

Q92. M0450-M0464. How can one OASIS tell whether a pressure ulcer has improved?

A92. The OASIS items are used for outcome measurement and risk factor adjustment. There are NO outcome measures computed for pressure ulcer improvement. Descriptive documentation in the patient's clinical record should address changes in pressure ulcer size and status that show improvement. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q93. M0445-M0464. How should these items be answered if a Stage 3 or Stage 4 pressure ulcer is completely healed?

A93. The healing of a pressure ulcer is never indicated by "reverse staging" of the ulcer. If this were the only ulcer the patient had, the appropriate responses would be M0440 = yes and M0445 = yes. M0450 would be answered by indicating the stage of the healed pressure ulcer at its worst, with M0460 answered accordingly. On OASIS item M0464, the "best possible" answer for a healed pressure ulcer would be "fully granulating." [Q&A EDITED 08/07]

Q94. M0445-M0464. If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure?

A94. If a pressure ulcer is closed with a muscle flap, the new tissue completely replaces the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed completely, but then began to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed completely, it would be considered a non-healing surgical wound.

Q95. M0445-M0464. If a pressure ulcer is debrided, does it become a surgical wound as well as a pressure ulcer?

A95. No, as debridement is a treatment procedure applied to the pressure ulcer. The ulcer remains a pressure ulcer, and its healing status is recorded appropriately based on assessment.

Q96. M0445-M0464. If a single pressure ulcer has partially granulated to the surface, leaving the ulcer open in more than one area, how many pressure ulcers are present?

A96. Only one pressure ulcer is present. The healing status of the pressure ulcer (for M0464) can be described by applying the *OASIS Guidance Document,* developed with

CMS by the Wound, Ostomy, and Continence Nurses Society (WOCN), found at http://www.wocn.org/. Other objective parameters such as size, depth, drainage, etc. should also be documented in the clinical record. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q97. M0445 - M0464. We have been advised that a pressure ulcer is always a pressure ulcer and should be staged as it was at its worst. Does this apply to stage 1 and stage 2 pressure ulcers?

A97. Based on current advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), CMS has modified its policy for coding the healing status of Stage 1 and Stage 2 pressure ulcers. This policy became effective September 1, 2004.

Stage 1 pressure ulcers heal to normal appearing skin and are not at increased risk for future ulcer development. Stage 2 ulcers generally heal to nearly normal appearing skin, but may result in scar tissue formation. Healed stage 2 pressure ulcers only minimally increase the future risk of pressure ulcers at that location.

During the SOC or subsequent comprehensive assessments of the patient, if it is found that a patient has a healed Stage 1 or 2 pressure ulcer, the responses for OASIS data items are as follows:

(M0440) Does this patient have a Skin Lesion or Open Wound?

- If the patient has a healed Stage 1 pressure ulcer (and no other pressure ulcers OR skin lesions/wounds), the response would be 'No'.
- If the patient has a healed Stage 2 pressure ulcer (and no other pressure ulcers OR skin lesions/wounds), the response may be either 'No' or 'Yes' depending on the clinician's physical assessment of the healed wound site.
  - If the patient has no scar tissue formation from the healed Stage 2 pressure ulcer, the accurate response is 'No'.
  - If the patient has some residual scar tissue formation, the response is 'Yes'.

(M0445) Does this patient have a Pressure Ulcer?

- If the patient has a healed Stage 1 or 2 pressure ulcer (and no other pressure ulcers), the accurate response is 'No', following the skip pattern as indicated.

[Q&A added 06/05] [Q&A EDITED 08/07]

Q98. M0445-M0464. Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4?

A98. No, a pressure ulcer that is covered with eschar cannot be staged until the wound bed is visible. The status of the pressure ulcer needs to correspond to the visual assessment by the skilled clinician on the date of the assessment. This is documented on the Wound, Ostomy, and Continence Nurses (WOCN) Association website at www.wocn.org in the WOCN Guidance Document and at the NPUAP site at www.npuap.org.
[Q&A added 06/05] [Q&A EDITED 08/07]

Q99. M0445-M0464. If a wound heals and breaks down again should it be staged at its prior level or should it be staged on the current level of breakdown?

A99. The type of wound is not identified here, but this response pertains to a healed pressure ulcer. This is the only type of wound that clinicians can stage. The appropriate response to this question for pressure ulcers will depend on the stage of the pressure ulcer at its worst prior to healing. If the ulcer was a Stage 1 or 2 prior to healing, then the updated guidance included in the response to Q97 (above) should be followed. The stage of this (newly deteriorated) pressure ulcer must be determined based on the current visual assessment by a clinician skilled in this clinical practice. If the ulcer was a Stage 3 or 4 at its worst prior to healing, then the ulcer's stage will be reported according to what it was at its worst. If the ulcer is worse now, the ulcer's stage at its worst (i.e., its current stage) also is what will be reported.

Q99.1. M0464. According to the WOCN Guidance on OASIS Skin and Wound Status M0 Items, a "non-healing" status applies to a pressure ulcer with greater than or equal to 25% avascular tissue and Early/Partial Granulation status applies to a pressure ulcer with minimal avascular tissue (i.e., less than 25% of the wound bed is covered with avascular tissue). Does this guidance supersede the Chapter 8 M0464 guidance that states "If part of the ulcer is covered by necrotic tissue then it is not healing (Response 3)?" What if only 5% of the wound bed is covered with eschar?

A99.1: Follow the WOCN guidance. If only 5% of the wound bed is covered with eschar, according to the WOCN guidance, the status would be Early/Partial Granulation, as long as the other criteria are met. To meet the criteria for "Non-healing", the portion of the wound bed coverage must be equal to or greater than 25% avascular tissue. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #25]

Q100. M0468-M0476. Would an arterial ulcer be considered a stasis ulcer?

A100. No, because venous stasis ulcers and arterial ulcers are unique disease entities. Refer to the WOCN web site (http://www.wocn.org/) for Clinical Fact Sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).

Q101. M0468-M0476. How can I determine whether the patient's ulcer is a stasis ulcer or not?

A101. The patient's physician is the best information source regarding the root cause of the ulcer. Refer to the WOCN web site (http://www.wocn.org/) for Clinical Fact Sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).

Q102. M0482-M0488. Is a gastrostomy that is being allowed to close on its own considered a surgical wound?

A102. A gastrostomy that is being allowed to close would be excluded from consideration as a wound or lesion (M0440), meaning that it could not be considered as a surgical wound. However, the "take-down" of an ostomy done as a surgical procedure

would result in both a wound/lesion ("yes" to M0440) and a surgical wound ("yes" to M0482).

Q103. M0482. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a surgical wound?

A103. For M0440 you would answer YES for a lesion. At M0482, response 1-Yes is appropriate. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion. [Q&A EDITED 08/07]

Q104. M0482. Are implanted infusion devices or venous access devices considered surgical wounds? Are these included in the "count" of surgical wounds? Does it matter whether or not the device is accessed routinely?

A104. Yes, the surgical sites where such devices were implanted would be considered surgical wounds and included in the total number of surgical wounds at M0484. It does not matter whether the device is accessed at a particular frequency or not.

Q105. M0482. If debridement is required to remove debris or foreign matter from a traumatic wound, is the wound considered a surgical wound?

A105. No. Debridement is a treatment to a wound, and the traumatic wound does not become a surgical wound. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #9]

Q105.1. M0482. If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be "counted" as a surgical wound for M0482, Surgical Wound and the subsequent surgical wound questions?

A105.1: Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #26]

Q105.2. M0482. Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or the sutured incision around a fresh ostomy.

A105.2: No, the presence of sutures does not automatically equate to a surgical wound. In the examples given, if the IV was peripheral, it would be excluded from M0440 and M0482, and a pressure ulcer does not become a surgical wound by being sutured closed, and the ostomy would be excluded from M0440 and M0482. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #27]

Q105.3. M0482. Since an implanted venous access device is considered a surgical wound for M0482, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device?).

A105.3: No. The surgical incision is considered a surgical wound until it is healed, becoming a scar. The site of the venous access device is initially considered a surgical wound, as long as it is in place. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #28]

Q105.4. M0482. If an abscess is incised and drained, does it become a surgical wound?

A105.4: No, an abscess that has been incised and drained is an abscess, not a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #29]

Q105.5. M0482. I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed?

A105.5: For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. The procedure would be reported as a surgical wound if a drain was placed following the procedure.

Also, if the abscess was surgically excised, the abscess no longer exists and the patient would have a surgical wound, until healed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #17]

Q105.6. M0482. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?

A105.6: When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #18]

Q105.7. M0482. Does a cardiac cath site qualify as a surgical wound for M0482?

A105.7: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #19]

Q105.8. M0482. Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration?

A105.8: Simply suturing a traumatic laceration does not create a surgical wound. A traumatic wound that required surgery to repair the injury would be considered a surgical wound (e.g., repair of a torn tendon, repair of a ruptured abdominal organ, or repair of other internal damage), and the correct response to M0482 for this type of wound would be "1-Yes." [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #20]

Q105.9. M0482. Is a PICC placed by a physician under fluoroscopy and sutured in place considered a surgical wound? It would seem that placement by this procedure is similar to other central lines and would be considered a surgical wound.

A105.9: Even though the physician utilized fluoroscopy to insert the peripherally inserted central catheter (PICC) and sutured it in place, it is not a surgical wound, as PICC lines are excluded as surgical wounds for OASIS data collection purposes. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #21]

Q105.10. M0482. If a surgical wound is completely covered with steri-strips is it considered non observable?

A105.10: Chapter 8 of the OASIS Implementation Manual states, "A [surgical] wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders." Although unusual, if the steri-strip placement did not allow sufficient visualization of the incision, and if the physician provided specific orders for the steri-strips to not be removed, then the wound would be considered not observable. However, a surgical wound with steri-strips should be considered observable in the absence of physician orders to not remove strips for assessment, or if usual placement allows sufficient visualization of the surgical incision to allow observation of clinical features necessary to determine the surgical wound's healing status (e.g., incisional approximation, degree of epithelialization, incisional necrosis (scab), and/or signs or symptoms of infection). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #8]

Q105.11. M0482. Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed?

A105.11: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482. The fact that a stent was placed does not have an impact. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #9]

Q106. M0482-M0488. Is a peritoneal dialysis catheter considered a surgical wound? If it is, how can the healing status of this site be determined?

A106. Both M0440 and M0482 should be answered "Yes" for a patient with a catheter in place that is used for peritoneal dialysis. You should consider the catheter for peritoneal dialysis (or an AV shunt) a surgical wound (as are central lines and implanted vascular access devices). To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "non-healing" unless the signs of not healing are apparent. Such a site, because it is being held open by the line itself, may not reach a "fully granulating" state. Assessing the healing status of such a wound is slightly more difficult than a 'typical' surgical site. As long as a device is present, the wound will be classified as a surgical wound. Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document)* found at http://www.wocn.org/ to determine when healing has occurred.

Q107. M0482-M0488. When does a wound no longer qualify as a surgical wound? When does CMS officially consider a wound to be healed?

A107. A wound no longer qualifies as a surgical wound when it is completely healed (thus becoming a scar). Utilizing skilled observation and assessment of the wound, follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document*) found at http://www.wocn.org/ to determine when healing has occurred. CMS does not follow time intervals in determining when a wound has healed, since the healing status of the wound can only be determined by a skilled assessment and the time for healing varies widely between patients. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #10]

Q108. M0482-M0488. How should these items be marked when the patient's surgical wound is completely healed?

A108. If the patient's surgical wound has healed completely, it is no longer considered a current surgical wound. The resulting scar would be noted as a "yes" response to M0440, but M0482 would be marked "no."

Q109. M0482-M0488. Is a mediport "nonobservable" because it is under the skin?

A109. Please refer to the definition of "nonobservable" used in the OASIS surgical wound items in the *OASIS User's Manual* – "nonobservable" is an appropriate response ONLY when a nonremoveable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound. If needed, the manual can be downloaded from http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp.[Q&A EDITED 08/07]

Q110. M0482-M0488. I've never seen a nonobservable surgical wound in my agency. Why is this item even included?

A110. There are situations where surgeons do not want others to remove the dressings that they have placed. In such situations, agencies know there is a surgical wound present, but they are unable to describe the wound status because they cannot observe the wound. Without M0486, the responses to the surgical wound item responses might be difficult to evaluate. In the national repository data, nearly 10% (i.e., 9.8%) of patients with surgical wounds at SOC/ROC had nonobservable wounds.

Q111. [Q&A DELETED 08/07; Outdated due to revision of WOCN guidance]

Q112. M0482. Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440, and a surgical wound for M0482?

A112. No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation.
[Q&A added 06/05]

Q112.1. M0488. A venous access device is routinely accessed and upon assessment has a scab at the puncture site. Assuming there are no signs or symptoms of infection, is the wound status early/partial granulation or fully granulating?

A112.1: To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document)* found at http://www.wocn.org/ to determine the status. Based on the WOCN guidelines, a wound with ≥ 25% avascular tissue is considered "non-healing"; therefore a venous access puncture site which is covered by a scab (avascular tissue) would be classified as Response 3 - non-healing. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #30]

Q112.2. M0488. Is it true that the status of a new surgical incision that is closed, with no signs or symptoms of infection present, well approximated, but with a small scab, should be evaluated at 3 - Not healing, even though the scab is normal part of incision healing? Since this potentially impacts reimbursement, we want to ensure we are doing it right.

A112.2: In order to determine the healing status of a surgical wound, clinicians are directed to rely on the "WOCN Guidance on OASIS Skin and Wound Status M0 Items" document available at www.wocn.org. This document provides guidance specific for determining the healing status for surgical wounds healing by primary intention, and separate guidance for wounds healing by secondary intention. A typical routine surgical incision as you describe would be considered healing by primary intention. Referencing the WOCN guidelines, it is noted that a wound that demonstrates incisional necrosis (of any amount for primary intention), is considered "Not Healing".

Note that if we were discussing a dehisced wound, we would be assessing a wound healing by secondary intention, and would follow different guidelines which take into consideration the amount of avascular tissue in determining the healing status (e.g. ≥ 25% = not healing).

For further clarification, review the CMS OCCB Q&A's (07/2006), Question #30 at www.oasiscertificate.org which confirms that a scab equates to avascular tissue, which the WOCN Document Glossary equates to necrotic tissue. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #10]

Q112.3. M0488. We are having a discussion as to whether a mediport is a "Not healing" or "Early/partial granulation" wound in M0488 when the needle is present in the wound. And if the needle has just been removed within the last 24 hrs how would it be scored; or if the site has not been accessed for several months and there is no open area visible how is it to be scored? We are assuming that this is a wound that is healing by secondary intention.

A112.3: The assessing clinician must determine the healing status of a wound following guidance in Chapter 8 of the OASIS User's Manual and the latest version of the WOCN's OASIS Guidance Document.

Some sites, because they are being held open by a line or needle, may not reach a "fully granulating" state while the line or needle is in place.

Once the needle is removed before a scab has formed, the wound bed may be clean but non-granulating. Based on the WOCN Guidance, the wound would be reported as Response 3 – Not healing for M0488. Or if the venous access device is routinely accessed and upon assessment has a scab at the puncture site, assuming there are no signs or symptoms of infection, a wound with greater than or equal to 25% avascular tissue is considered "non-healing". Therefore a venous access puncture site which is covered by a scab (avascular tissue) would also be classified on M0488 as Response 3 – not healing.

If the site has not been accessed for months, then guidance from CMS OASIS Q&As Category 4b Q106 assists in determining the healing status of an implanted vascular access device by suggesting that to answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "non-healing" unless the signs of not healing are apparent. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #11]

Q113. M0490. How should I best evaluate dyspnea for a chairfast (wheelchair-bound) patient? For a bedbound patient?

A113. M0490 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath with varying levels of exertion are presented. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. If the patient does not have shortness of breath with moderate exertion, then either response 0 or response 1 is appropriate. If the patient is never short of breath on the day of assessment, then response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities, then response 1 seems most appropriate.

In the case of the bedbound patient, the level of exertion that produces shortness of breath should also be assessed. The examples of exertion given for responses 2, 3, and 4 also provide assessment examples. Response 0 would apply if the patient were never short of breath on the day of assessment. Response 1 would be most appropriate if demanding bed-mobility activities produce dyspnea. [Q&A EDITED 08/07]

Q113.1. M0490. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.

A113.1: Since the patient's supplemental oxygen use is not continuous, M0490 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – At rest (during day or night)". It would be important to include further clinical documentation to explain the patient's specific condition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #31]

Q113.2. M0490. What is the correct response to M0490, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea?

A113.2: Sleep apnea being treated by CPAP is not the same as dyspnea at rest (response 4 for M0490). M0490 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M0490. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then response 4 - At rest (during day or night) should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #12]

Q113.3. M0490. Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. Would you mark M0490, #4 At Rest or 0 Never SOB?

A113.3: M0490 reports what is true at the time of the assessment (the 24 hours immediately preceding the visit and what is observed during the assessment). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would be "0-Never" even though the environment or patient activities were modified in order to avoid shortness of breath. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #13]

Q114. M0500. How should I respond to M0500 for the patient receiving Bi-PAP (not CPAP, as included in response 3)?

A114. Note that the Response-specific Instructions for M0500 direct you to exclude any respiratory treatments that are not specifically listed in the item. If the patient's only respiratory treatment is Bi-PAP without oxygen, the appropriate response is 4, "None of the above." If the patient uses any of the listed treatments, the appropriate response(s) should be noted. If the patient was receiving oxygen, including delivery in conjunction with the Bi-PAP treatment, then the oxygen use would be reported in Response 1. In either case, the use of Bi-PAP would be documented in the patient's clinical record. [Q&A EDITED 08/07]

Q114.1. M0500. If patient is on a ventilator, do you mark O2 & ventilator or is the O2 inclusive with the ventilator in this question?

A114.1: M0500 instructs the assessor to mark all that apply. As it is possible for a patient to be ventilated with entrained room air and thus be on a ventilator without oxygen therapy, it would be accurate to mark both Responses 1-Oxygen and 2-Ventilator when the patient is receiving oxygen through the ventilator. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #14]

Q115. [Q&A DELETED 08/07; Duplicative of Chapter 8]

Q116. M0510. If a patient had signs and symptoms of a UTI but no prescribed treatment or the treatment ended more than 14 days prior to the assessment, what would be the best response for M0510?

A116. In either of these situations, the appropriate response would be "no."

Q117. M0520. Is the patient incontinent if she only has stress incontinence when coughing?

A117. Yes, the patient is incontinent if incontinence occurs under any situation(s).

Q118. M0520. A new urologist has just started referring patients who have a urostomy or ureterostomy. What should I mark for M0520?

A118. A urostomy or ureterostomy is considered an ostomy for urinary drainage. The appropriate response therefore is "0 - no incontinence or catheter." The appropriate skip pattern should then be followed.

Q119. M0520. A patient is determined to be incontinent of urine at SOC. After implementing clinical interventions (e.g., Kegel exercises, biofeedback, and medication therapy) the episodes of incontinence stop. At the time of discharge, the patient has not experienced incontinence since the establishment of the incontinence program. At discharge, can the patient be considered continent of urine for scoring of M0520, to reflect improvement in status?

A119. Assuming that there has been ongoing assessment of the patient's response to the incontinence program (implied in the question), this patient would be assessed as continent of urine. Therefore Response 0, no incontinence or catheter, is an appropriate response to M0520.

Timed-voiding was not specifically mentioned as an intervention utilized to defer incontinence. If, at discharge, the patient was dependent on a timed-voiding program to defer incontinence, the appropriate response to M0520 would be 1 (patient is incontinent), followed by response 0 to M0530 (timed-voiding defers incontinence). [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #5]

Q119.1. M0520. How long would a patient need to be continent of urine in order to qualify as being continent?

A119.1: Utilize clinical judgment and current clinical guidelines and assessment findings to determine if the cause of the incontinence has been resolved, resulting in a patient no longer being incontinent of urine. There are no specific time frames that apply to all patients in all situations. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #23]

Q120. M0530. How should I respond to M0530 for the patient with an ureterostomy?

A120. If the patient had an ureterostomy, M0520 should have been answered with response 0 (no incontinence or catheter). From response 0, directions are to skip M0530. You should not be responding to M0530 if the patient has an ureterostomy.

Q121. M0530. If patient had stress incontinence during the day that was not deferred by timed-voiding, how would M0530 be completed?

A121. Response 2 at M0530 is the only response that includes the time period of 'day'. Therefore, that response would be the appropriate one to mark. If there were a caregiver, he/she might consider timed-voiding measures to assist in deferring the patient's incontinence during the day.

Q121.1. M0530. If a patient is utilizing timed-voiding to defer incontinence and they have an "accident" once-in-a-while, can you still mark M0530 "0 – Timed-voiding defers incontinence"?

A121.1: If the patient utilizes timed-voiding but still has an "occasional" accident, determine when the accidents occur and mark either Response 1 "during the day and night" or 2 "during the night only". CMS does not offer specific timeframes to define the term "occasionally". Clinical judgment will be required to determine if the last urinary accident is in the relevant past or if the patient's current use of timed-voiding is 100% effective and therefore should be marked as "timed-voiding defers incontinence". [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #32]

Q122. M0540. How should you respond to this item if the patient is on a bowel-training program? How would that be documented in the clinical record?

A122. A patient on a regular bowel evacuation program most typically is on that program as an intervention for fecal impaction. Such a patient may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The patient's elimination status must be completely evaluated as part of the comprehensive assessment, and the OASIS items answered with the specific findings for the patient. The bowel program, including the overall approach, specific procedures, time intervals, etc., should be documented in the patient's clinical record.

Q123. M0550. If a patient with an ostomy was hospitalized with diarrhea in the past 14 days, does one mark Response 2 to M0550?

A123. Response #2 is the appropriate response to mark for M0550 in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

Q124. M0570. If a patient has experienced episodes of recent confusion, but does not demonstrate or report any episodes of confusion today (the date of the assessment), would the patient be considered "never" confused? Or should the recent history of confusion be considered when responding to M0570?

A124. Information collected from patient or caregiver report can be utilized in responding to M0570. This includes reports that extend beyond the day of the assessment into the recent past. Therefore, if the patient or family reported that the patient has experienced periods of confusion on awakening a few mornings over the last week, it would be appropriate to mark "2" on awakening or at night only for M0570, even if no confusion was experienced *today*. This same strategy (of utilizing reported information from the recent past) also applies to the scoring of anxiety in M0580 and

depressive feelings in M0590. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #11]

Q124.1. M0570 & M0580. What does unresponsive mean?

A124.1: It means the patient is unconscious, or is unable to voluntarily respond. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered "unresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simple refuses to answer questions should not automatically be considered "unresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

Q125. M0620. Are the behaviors to be considered in responding to this item limited to only those listed in M0610?

A125. No, there are behaviors other than those listed in M0610 that can be indications of alterations in a patient's cognitive or neuro/emotional status resulting in behaviors of concern for the patient's safety or social environment. Other behaviors such as wandering can interfere with the patient's safety, and if so, the frequency of these should be considered in responding to the item.[Q&A EDITED 08/07]

Q126. M0630. At discharge, does M0630 pertain to the services the patient has been receiving up to the point of discharge or services that will continue past discharge? The psych nurse is the only service being provided.

A126. OASIS items refer to what is true at the time of the assessment (unless a specified time point is noted, such as 14 days ago). Therefore, for the situation described, if the psych nurse is the only service provided at the time of the discharge assessment, the correct response is "yes." Note that if the psychiatric nurse discharges on Tuesday, but the Physical Therapist does the discharge comprehensive assessment on Wednesday, then M0630 (at discharge) would not reflect the presence of psychiatric nursing services. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #3]

NOTE: For OASIS items M0640-M0820, the patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies, chose the response describing the patient's ability more than 50% of the time. See the *OASIS User's Manual* page 8.89 for more details.

Q127. M0640-M0800. At OASIS items M0640-M0800, what does IADL mean and what's the difference between IADLs and ADLs?

A127. ADL stands for 'activities of daily living' while IADL stands for 'instrumental activities of daily living'. ADLs refer to basic self-care activities (e.g., bathing, dressing, toileting, etc.), while IADLs include activities associated with independent living

necessary to support the ADLs (e.g., use of telephone, ability to do laundry, shopping, etc.). There is a more complete discussion of this topic in the *OASIS User's Manual*, Chapter 8, Item-by-Item tips, on the page preceding the tips for items M0640-M0800.

Q128. M0640-M0800. With regard to the start of care data set, what time frame do we select for IADL's/ADL's if we are to complete 'prior' 14 days before start of home care and the patient was in the hospital at that time? Is this 14 days prior to the hospitalization or 14 days before start of care, which would be while the patient was in the hospital?

A128. For M0640 - M0800, the time frame for the 'prior' ADL/IADLs should reflect the 14th day directly before start of home care, which would be while the patient was in the hospital.

Q128.1. M0640-M0800. I know it is imperative that the assessing clinician be accurate on answering what the patient's status was on the "14th day prior to". Can you explain to me the importance of that 14th day? What bearing this has on their outcomes/payment? If we mark "unknown", does it hurt the agency?

A128.1: Prior status contributes to the Case Mix Report categories of "ADL Status Prior to SOC" and "IADL Status Prior to SOC" and is utilized in risk adjustment for some of the outcome measures. The "prior status" variables have proven to be particularly useful in risk adjustment for the OBQI reports, as they indicate the chronicity of a functional impairment (thus impacting the patient's expected ability to improve in a specific outcome of interest).

The 14th day prior to SOC/ROC serves as a proxy for the patient's prior functional status. While it may not represent the "true" prior functional status, it allows the data collection of thousands of assessors to be standardized. General OASIS conventions state that data collectors should minimize the use of "unknown" as a response option, and to limit its use to situations where no other response is possible or appropriate. Under the current reimbursement for Medicare home care services, the "14 days prior" responses do not affect payment. However, since the responses from the prior status items do currently contribute to risk adjustment, it is possible that they may have a reimbursement impact in the future, depending on the parameters used to determine payment under the home health benefit and other programs. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #24]

Q129. M0640. Must I see the patient comb his/her hair or brush his/her teeth in order to respond to this item?

A129. No, as assessment of the patient's coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient's ability to perform grooming activities.

Q130. M0640. Is toileting hygiene part of this item?

A130. The term "toileting hygiene" typically is used to refer to the activities of managing clothing before and after elimination and of wiping oneself after elimination. If these are the activities implied by this question, the response is "no, toileting hygiene is not part of

this item." If the question refers to the patient's ability to wash his/her hands, this activity is considered part of grooming.

Q130.1. M0640 & M0670. Is hair washing/shampooing considered a grooming task, a bathing task, or neither?

A130.1: The task of shampooing hair is not considered a grooming task for M0640. Hair care for M0640 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M0670, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #34]

Q131. M0650. If the patient is wearing a housecoat, should I evaluate her ability to dress in the housecoat or in another style of clothing?

A131. The appropriate response should indicate the patient's ability to dress herself (or the level of assistance needed to dress) in whatever clothing she would routinely wear. If the patient routinely wears another style of clothing, the assessment should include the skills necessary to manage zippers, buttons, hooks, etc. associated with this clothing style.

Q132. M0650. What if the patient must dress in stages due to shortness of breath? What response must be marked?

A132. If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then response 2 is appropriate. (Note that the shortness of breath would be addressed in M0490.)

Q132.1. M0650, M0660. In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing?

A132.1: M0650 & M0660, Upper and Lower Body Dressing, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the assessment time point, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #25]

Q132.2. M0650, M0660, M0780. For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?

The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"

A132.2: Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

Q132.3. M0660. If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g. patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M0660?

A132.3: M0660 identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. A prescribed treatment that is integral to the patient's prognosis and recovery from the episode of illness, such as elastic compression stockings, air casts, etc., should be considered when scoring M0660. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items, as the elastic compression stockings are a required, prescribed treatment. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #35]

Q133. M0670. For patients whose regular habit is to sponge bathe themselves at the lavatory, what should be marked for M0670?

A133. As noted in the Item-by-Item Tips found in Chapter 8 of the *OASIS User's Manual*, the patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her ability to bathe in the tub or shower. What assistance would be needed for the patient to be able to wash their body in the tub or shower? For example, if it is determined that the patient would be able to safely wash their body in the shower or bathe in the tub with the presence of another person throughout the bath for safety or assistance, response #2 would be marked. [Q&A EDITED 08/07]

Q134. M0670. Given the following situations, what would be the appropriate responses to M0670?

a) The patient's tub or shower is nonfunctioning or is not safe for use.
b) The patient is on physician-ordered bed rest.
c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.
d) The patient chooses not to navigate the stairs to the tub/shower.

A134. a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.

b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment.

c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then response 3 would describe her ability.

d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured. [Q&A EDITED 08/07]

Q135. M0670. How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink?

A135. The item addresses the patient's ability to bathe in the shower or tub, regardless of where or how the patient currently bathes. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and response 1, 2, or 3 should be selected.

Q136. M0670. Should the clinician consider the patient's ability to perform bathing-related tasks, like gathering supplies, preparing the bath water, shampooing hair, or drying off after the bath in responding to this item?

Q136. When responding to M0670, only the patient's ability to "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #12]

Q137. M0670. If a patient can perform most of the bathing tasks (i.e. can wash most of his/her body) in the shower or tub, using only devices, but needs help to reach a hard to reach place, would the response be "1" because he/she is independent with devices with a "majority" of bathing tasks? Or is he/she a "2" because he/she requires the assist of another "for washing difficult to reach areas?"

A137. The correct response for the patient described here would be Response 2 "able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas," because that response describes that patient's ability at that time. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #13] [Q&A EDITED 08/07]

Q138. M0670. Please clarify how the patient's ability to access the tub/shower applies to M0670.

A138. M0670 defines the bathing item to identify the patient's ability to wash the entire body. Guidance for this item also indicates that when medical restrictions prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. Tasks related to transferring in and out of the tub or shower are evaluated and scored when responding to M0690 – Transferring, and they are not considered part of the bathing tasks for M0670. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #6]

Q139. M0670. A patient is unable to participate in the bathing tasks and is totally bathed by a caregiver, but the caregiver bathes the patient in the shower (i.e., lifts the patient into a shower chair, rolls patient to the shower, and bathes the otherwise passive patient). Response 5 states that the patient is unable to effectively participate in bathing and is totally bathed by another person. Please clarify if this patient would be noted to be at response level 5 because they are unable to effectively participate in bathing and are totally bathed by another person or at level 3 because the patient requires the presence and assistance of another person to bathe in the shower?

A139. If the patient truly is unable to effectively participate in any part of the bathing tasks in the shower, response 5 is appropriate. If the patient is able to participate at all in the bathing tasks in the shower, then response 3 is appropriate.
[Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #6]

Q140. M0670. If the only reason the patient can't bathe in the tub is because they can't perform the transfer safely, even with equipment and assistance, should they be at response level 4 or 5 (Unable to use the shower or tub) even though the only reason is the transfer status, and transferring is not supposed to be considered in responding to M0670?

A140. The tub transfer should not be considered when responding to M0670. However, the response for M0670 should differentiate patients who are <u>able</u> to bathe (or be bathed) in the tub or shower (i.e., responses 0, 1, 2, 3, or 5) from those who are <u>unable</u> to bathe in the tub or shower (e.g., response 4) regardless of the specific cause or barrier preventing the patient from bathing in the shower or tub. Responses 0,1,2,3, reflect patients who are able to get in/out of the tub/shower, assisted or unassisted by any safe means and once in the tub/shower are able to safely participate in washing their body, either independently or with assistance. Responses 4 reflects patients who

are unable to get in/out of the tub/shower, assisted or unassisted by any safe means and therefore participate in washing their body outside of the tub/shower, either independently or with assistance. Response 5 reflects patients who are unable to participate in the tasks required to wash their body, regardless of whether or not the patient is able to get in/out of the tub/shower (e.g. the dependent bather is bathed in the bed, chair, or after being rolled into the shower in a shower chair).
[[Q&A added 06/05; Previously CMS OCCB 3/05 Q&A Q #7] [Q&A EDITED 08/07]

Q141. M0670. Since the transfer into/out of the tub/shower should not be considered when responding to M0670, is it acceptable for assessing clinicians to ignore Response 2(b) from the item wording?

A141. The tub or shower transfer should not be considered when responding to M0670, and if the transfer is the only bathing task for which a patient requires help to bathe safely in the tub/shower, then the patient should be scored a 0 or 1, depending on his/her need for devices to safely perform all the included bathing tasks independently. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #8]

Q141.1. M0670. Based on my SOC comprehensive assessment, I determine that my patient requires assistance to wash his back and feet safely in the tub. At the time of the assessment, I believe the patient *could* wash his back and feet safely *if* he had adaptive devices, like a long-handled sponge. Should the initial score be "1" able to bathe in the tub/shower with equipment or "2" requires the assistance of another person to wash difficult to reach areas?

A141.1: Since at the time of the assessment the patient requires intermittent assist of another person to wash difficult to reach areas, then response "2" should be selected. If the clinician determined that the patient could become more independent (i.e., require less assistance) with the use of adaptive equipment, then such equipment could be obtained or recommended as part of the home health plan of care. If at discharge the patient is able to wash his entire body using the equipment provided, then response "1" should be reported. If the patient is financially unable or otherwise refuses to obtain the recommended equipment, then the clinician would not have the opportunity to instruct or evaluate the patient's ability to determine if the equipment improves independence. If the patient does not get the equipment, or if even with the equipment the patient continues to require intermittent assistance, then response "2" would apply. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #36]

Q141.2. M0670. I understand that recent clarification reveals that the transfer in/out of the tub/shower should not be included in the scoring of M0670. Previous guidance stated that in order for the patient to be able to bathe in the tub/shower they had to be able to get there (e.g., if a patient is restricted from stair climbing and their only tub/shower is upstairs, then they are unable to bathe in the tub/shower) Is this still true or is M0670 now limited to just the patient's ability to wash their entire body once in the tub/shower? It seems strange that walking up the stairs *would* impact the bathing item score, but getting into the tub/shower *wouldn't.*

A141.2: Guidance for this item has evolved over time and additional clarification has been provided, allowing objective measurement of improvement in a specific portion of the bathing process; the patient's ability to wash their entire body. If a patient can get to

the tub/shower and in/out of the tub/shower (by any safe means), then their ability to wash their entire body while in the tub/shower should be assessed, and the score reported as "0" if they need no human assistance or equipment, "1" if they need no human assistance but require equipment, "2" if they require intermittent assistance, "3" if they require constant supervision/assistance, "4" if they are unable to use the shower or tub and is bathed in bed or bedside chair, or "5" if they are unable to participate at all in washing their body. If medical restrictions prohibit the patient from activities which would be required for the patient to get to/from the tub/shower (e.g., restricted stair climbing), in/out of the tub/shower (e.g., some joint precautions), or from bathing or showering in the tub or shower (e.g., some cast or incision precautions), then the patient should be considered "unable to bath in the tub or shower" and would be scored a "4" or "5", depending on their ability to participate in washing their body at any location outside of the tub/shower. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #37]

Q141.3. M0670. For M0670 even the normal person requires a long-handled sponge or brush to wash their back. However, the July 27 CMS OCCB Q & A's # 36 indicates that if a patient can do everything except wash their back & requires a long-handled sponge or brush they would be marked a "1". Is this correct?

A141.3: Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to, or had great difficulty safely performing. The intention of the use of the term "devices" in the response 1 for M0670 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not "require" special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient's use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient's ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines "devices" for the scoring of M0670. The clinician should assess the patient's ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #27]

Q141.4. M0670. If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a "4" in M0670?"

A141.4: Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient's personal preference to bathe at the sink (e.g. "I don't get that dirty." "I like using the sink."), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient's ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower when it was empty. If

the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient as "4 –"Unable to use the shower or tub and is bathed in bed or bedside chair.", unless they are a "5", unable to participate in bathing and is totally bathed by another person. Note that the response of "4" (or "5") is due to the patient's inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #28]

Q142. M0680. If my patient has a urinary catheter, does this mean he is totally dependent in toileting?

A142. M0680 does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient's ability to get to and from the toilet or bedside commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

Q143. M0680. If the patient can safely get to and from the toilet independently during the day, but uses a bedside commode independently at night, what is the appropriate response to this item?

A143. If the patient chooses to use the commode at night (possibly for convenience reasons), but is able to get to the bathroom, then response 0 would be appropriate.

Q144. M0680. If a patient is unable to get to the toilet or bedside commode and uses a bedpan for elimination, what response applies if the patient is able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?

A144. In M0680, the patient does not need to empty the bedpan or urinal to be considered independent. If the patient required assistance to use the bedpan/urinal (i.e., get on or off the bedpan or position the urinal), Response 4 would be the best response. If the patient could position the urinal or get on/off the bedpan independently, Response 3 would be appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #14]

Q145. M0680. The Item-by-Item pages in Chapter 8 state that personal hygiene and management of clothing are not included in scoring, so could "independent use of bedpan" as indicated by response "3" allow someone to help with clothing management and hygiene and still be considered "independent?"

A145. Tasks related to personal hygiene and management of clothing should not be considered when responding to M0680. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #15]

Q146. M0680. If a patient is able to safely get to and from the toilet with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M0680?

A146. The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet with assistance, then response 1 should be selected, as

this reflects their ability, regardless of the availability of a consistent caregiver in the home. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #9]

Q147. M0680. Is the transfer on/off the toilet included in responding to M0680? What about the transfer on/off the bedside commode? What about the transfer on/off the bed pan?

A147. M0680 does not include the transfer on and off the toilet (for response levels 0 and 1) or on/off the bedside commode (for response 2), as both these transfers are specifically addressed in responding to M0690 - Transferring. The transfer on and off the bedpan *is* considered for M0680 response level 3. If the patient requires assistance to get on/off the bedpan, then he/she would not be considered independent in using the bedpan and response 4 would be the best response. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #10]

Q148. M0680. If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of responding to M0680?

A148. Yes, a patient who is able to safely get to and from the toilet should be scored at response levels 0 or 1, even if they require the use of a commode over the toilet. Note that the location of such a commode is not at the "bedside," and the commode is functioning much like a raised toilet seat. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #11]

Q149. M0690. My patient must be lifted from the bed to a chair. He cannot turn himself in bed and is unable to bear weight or pivot. How would I respond to M0690?

A149. Response 3 is the option that most closely resembles the patient's circumstance you describe. The patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast ("confined to the bed") even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast.

Q150. M0690. If other types of transfers are being assessed (e.g., car transfers, floor transfers), should they be considered when responding to M0690?

A150. Because standardized data are required, only the specific transfer tasks listed in M0690 should be considered when responding to the item. Based on the patient's unique needs, home environment, etc., transfer assessment beyond bed to chair, toilet/commode, or tub/shower transfers may be indicated. Note in the patient's record the specific circumstances and patient's ability to accomplish other types of transfers.

Q151. M0690. If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?

A151. You appear to be asking about a patient who is not bedfast. Remember that M0690 evaluates the patient's ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of tub or shower. "Pushing up with both arms" could apply to two of these transfer types -- bed to chair and on/off toilet or commode. Taking extra time and pushing up with both arms can help ensure the

patient's stability and safety during the transfer process but does not mean that the patient is not independent. If standby human assistance were necessary to assure safety, then a different response level would apply to these types of transfers. Remember that transfer ability can vary across these three activities. The level of ability applicable to the majority of the activities should be recorded.

Q151.1. M0690. When scoring M0690 – Transferring, response "1" indicates that that patient requires minimal human assistance or the use of an assistive device to safely transfer. What constitutes an "assistive device" for the purposes of differentiating "truly independent" transferring (response "0") from "modified independent" transferring (response "1", or transferring with equipment)?

A151.1: CMS is in the process of defining assistive devices and will provide guidance when the issue is clarified. [Q&A ADDED 08/07. Previously CMS OCCB 08/04 Q&A #16]

Q151.2. M0690. If a patient requires a little help from the caregiver to transfer (e.g., verbal cueing, stand by assist, contact guard), would the score for M0690 Transferring be "1" (requires "minimal human assistance") or a "2" ("unable to transfer self")? Both seem to apply.

A151.2: If the patient is able to transfer self but requires standby assistance or verbal cueing to safely transfer, response "1" would apply. If the patient is unable to transfer self but is able to bear weight and pivot when assisted during the transfer process, then response "2" would apply. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #38]

Q151.3. M0690. A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M0690, is the patient considered bedfast?

A151.3: A patient who can tolerate being out of bed is not "bedfast." If a patient is able to be transferred to a chair using a Hoyer lift, response 3 is the option that most closely resembles the patient's circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast ("confined to the bed") even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient's ability to be transferred and tolerate being out of bed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #29]

Q151.4. M0690. How do you select a score for M0690 – Transferring, for the patient who is not really safe at response 1, but moving to response 2 seems a bit aggressive? Response 1 uses the word "or" NOT "and". If a patient requires both human assist AND an assistive device, does this move them to a 2, especially if they are not safe? It seems these patients can do more than bear weight and pivot--but it is the next best option. If they require human assist AND an assistive device, should we automatically move the patient to a "2", whether they are safe or not?

Answer 151.4: If the patient is able to safely transfer with either minimal human assistance (but no device), or with the use of an assistive device (but no human assistance) then they should be reported as a "1-Transfers with minimal human

assistance or with use of an assistive device". If they are not safe in transferring with either of the above circumstances, (e.g., they transfer with only an assistive device but not safely, minimal assistance only is not adequate for safe transferring, or they require both minimal human assistance and an assistive device to transfer safely), then the patient would be scored a "2–Unable to transfer self but is able to bear weight and pivot during the transfer process"(assuming the patient could bear weight and pivot). Safety is integral to ability. If the patient is not safe when transferring with just minimal human assistance or with just an assistive device, they cannot be considered functioning at the level of response "1".

For the purposes of Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete the task. Examples of environmental set-up as it relates to transferring would be a patient who requires someone else to position the wheelchair by the bed and apply the wheelchair locks in order to safely transfer from the bed to the chair, or a patient who requires someone else to place the elevated commode seat over the toilet before the patient is able to safely transfer onto the commode. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #15]

Q151.5. M0690. The patient is severely disabled with MS, is obese, cannot support her weight and the spouse is able to use a Hoyer lift to transfer her to a chair. Because of her size, she is not able to use a bedside commode. The bathroom entrance and layout does not allow for the Hoyer to pass through, so the patient is unable to be transferred to the bathroom toilet or into the shower. She can only do one of the three transfers via lift. She is not "confined to the bed" because she is able to be lifted to a chair. When in bed, she needs help turning and positioning. Is she a response 3 or a 5? Which principles apply and how would the transfer question be scored in this instance?

A151.5: When selecting the correct response to a multi-task item like Transferring, you must first determine if your patient is bedfast or not. If the patient is bedfast, the response will be 4 or 5. If the patient is not bedfast and their ability varies between the three transfers, determine what is true in a majority of the more frequently performed transfers. Bedfast means that a patient is unable to tolerate being out of the bed. They are confined to the bed. You state that your patient is transferred out of bed via the Hoyer lift and sits in a chair, so she is not bedfast. Even though the patient is only able to perform one of the three transfers, due to environmental and physical barriers, Response 3 best describes this patient. In the most frequently performed transfer, she is unable to transfer self and is unable to bear weight or pivot when transferred by another person. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #16]

Q152. M0700. What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are <u>able</u> to do and what they are <u>allowed</u> to do may be different. How should I respond to this item?

A152. The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to <u>safely</u> accomplish at the time of the assessment.